# the MODERN HOSPITAL

VOLUME 51 AUGUST 1938 NUMBER 2

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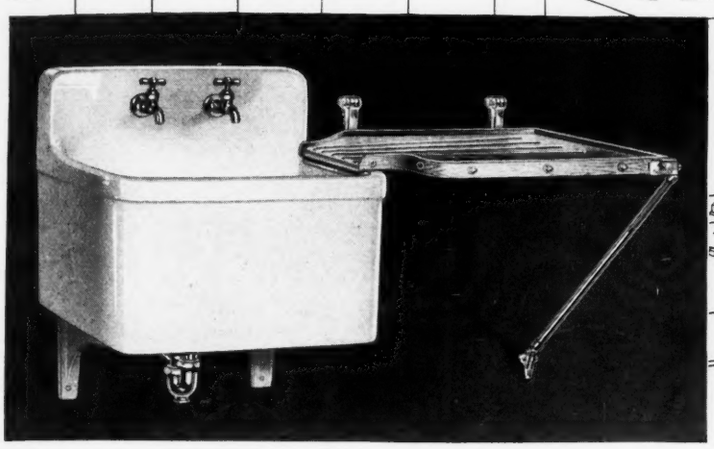

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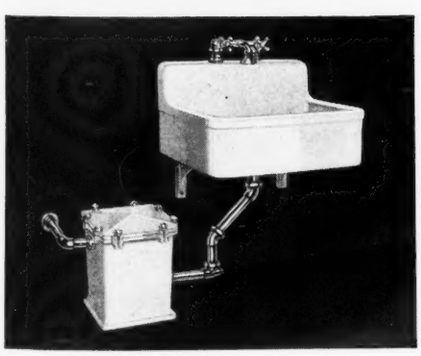

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# WITH THE ROVING REPORTER

### Lenox Hill "Braces Up"

• For many months we had been told about a brace shop that John Hayes, superintendent, Lenox Hill Hospital, New York, threatened to install in an adjoining one story wing in the interior yard of the hospital. Something of the kind was essential because of the growth of the orthopedic division of the hospital, orders previously having been handled by outside contractors.

Then one day in spring came the announcement that the Lenox Hill brace shop was opened for business. Funds had been provided by the Martha M. Hall Foundation. Business was evidenced by the fact that during its first month of operation orders were so numerous that it became necessary to put on additional help. Three mechanics simply couldn't handle it all. Interested visitors likewise contributed to the bustle of activity.

So if you would keep abreast of hospital doings in New York, you will put on your preferred list the brace shop at Lenox Hill. Without detracting from the pleasure of your own personal inspection it may be said that the layout comprises a machine and plaster room, leather room, celluloid room and fitting room. Here you will find all necessary equipment, including forge, buffers, grinders, cutting and drill presses, sewing machinery and a plaster bandage machine.

"One of the advantages of the shop," Mr. Hayes explained on a personally conducted tour, "is the ability to arrange for prompt and frequent fittings, thus enabling the hospital to restore patients to their normal lives sooner and keeping down patients' expense as well as that of the hospital."

### Health Talks at Salem

• Oliver G. Pratt, superintendent at Salem Hospital, Salem, Mass., is already beginning to plan for the second series of Sunday afternoon health talks next winter. But possibly we're getting ahead of our story. For those who may not have been in the vicinity of Salem last January and February, we should explain that a course of eight lectures was held in the nurses' home "to help in the general movement throughout the country to prevent disease."

To quote from the little announcement: "The promotion of health and the prevention of disease are as much the responsibility of the medical profession and the community hospital as the alleviation of suffering and the curing of ills. The Salem Hospital is happy to collaborate with the medical profession of the community in the furtherance of these objectives."

First in the series was a dramatic presentation by the administrative staff, forming an introduction to the functions of the general hospital. The enthusiastic audience numbered some 130 persons. Topics covered later were: the public health problems of the community, appendicitis and other abdominal emergencies, group insurance, high blood pressure and heart disease, the common cold and its complications, tuberculosis and advances in treatment, home use of drugs and the family medicine chest.

Despite the fact that the hospital is located on the outskirts of the city about a mile from the center of town, attendance ran from as high as 174 when appendicitis was discussed to a low of 35 on the afternoon when the subject was tuberculosis. The low attendance on that day, however, was attributed to a severe blizzard rather than to any lack of interest. Average attendance was 113, evincing real response, particularly to surgical procedure.

Today, as indicated at the start, Mr. Pratt is already at work with the committee of the medical staff on suggestions for subjects for the 1939 session. What do you suppose he is contemplating? We'll let Mr. Pratt tell you himself.

"We're planning to have our dermatologist talk on the effect of cosmetics on the skin, as we feel this would be a subject of real interest and value. We are also considering having our pathologist and our roentgenologist give talks although the subjects have not yet been selected."

We'll place a wager on the fact that Mr. Pratt will pack 'em in.

### Way to a Girl's Heart

• They say that the way to a man's heart is through his stomach. But is man any different from the "gentler sex," as it was known in the good old days?

This trend of thought occurred while visiting with Juanita Trapp, dietitian, Orange Memorial Hospital, Orange, N. J. Surely there could be no greater satisfaction or contentment revealed in a group than was manifest by the girls sitting around the tables in the nurses' dining room during lunch hour.

There hasn't been a complaint about the hospital food for many a day—at least since Miss Trapp announced a choice of two main luncheon dishes. "What will it be—a combination sandwich on rye, that is, sliced ham and Swiss cheese, with salad, or escalloped tunafish?" On another occasion it may be a question of baked Italian spaghetti with coleslaw, or fruit salad.

The girls consider the matter seriously and make their selection. In only a few instances have they taken advantage of the sporting proposition and ordered two dishes.

There is no question that the opportunity for choice creates better satisfaction. Nor has it tended to increase food costs. Two dishes somewhat lighter and less pretentious cost no more than one more elaborate item. It is the aim to offer one hot and one cold dish, the hot dish having a cold salad accompanying it. The nurses are pleased with the arrangement, which has led Miss Trapp to the conclusion that with girls, too, the way to the heart lies through the stomach.

### Wichita's "Iron Lung"

• Native sons of Kansas—Wichita, to be specific—are still boasting of their "iron lung." Thereby hangs a tale that bears repeating.

It happened like this: Citizens became aroused over the need of a respirator for hospital use, a fact called to their attention by the *Wichita Beacon*. That newspaper proceeded to sponsor a campaign to raise the necessary funds with which to purchase the equipment and a committee was appointed to direct the drive. The committee was comprised of a prominent attorney, the president of the medical society, an active club woman, a minister and a business man.

This group of citizens, stimulated by the generous publicity accorded the project by the newspaper, resulted in raising approximately $1500 in two weeks. Selection of the respirator was left to chiefs of the staffs of the city's three hospitals.

So the "iron lung" became a reality. To show no partiality in selecting the institution which would first offer this modern contrivance a home, the committee of doctors drew lots. Following its use in the lucky hospital for one year it will then be rotated so that each of the three will have it for a like period. Surely nothing could be fairer!

# LOOKING FORWARD

## Hospital Care and the A.M.A.

CONFLICTING stories have been reported of the action taken by the recent convention of the American Medical Association regarding medical service in hospitals. Apparently the reason for the conflict is that the action itself is contradictory.

At the meeting on Tuesday morning, June 14, the delegates adopted a resolution prepared by the council on medical education and hospitals directing that the council, jointly with the bureau of medical economics, make a study of the practice of medicine in hospitals by radiologists, pathologists and anesthetists. This joint committee was authorized to "confer with other agencies," to "establish ethical standards" and thus "to prevent the exploitation of either the public or the profession."

In spite of the fact that no mention is made of protecting the hospital from exploitation, this need doubtless was considered. The action was timely and proper. Hospitals have come to respect the council on medical education and hospitals for its fine work extending over many years. So far, so good.

But apparently the delegates are short of memory. On Thursday afternoon the reference committee on legislation and public relations recommended, and the delegates adopted, an amendment to the famous ten principles promulgated in 1937. This amendment, prepared by the bureau of medical economics, deals with hospital care insurance and reads as follows:

"If for any reason it is found desirable or necessary to include special medical services, such as anesthesia, radiology, pathology or medical services provided by out-patient departments, these services may be included only on the condition that specified cash payments be made by the hospitalization organization directly to the subscribers for the cost of the services."

The house of delegates, therefore, has directed that a careful study be made of an important and complicated subject and then, without waiting for the results of this study, has prejudged the case. Naturally hospital administrators and trustees will be somewhat perplexed if invited by the council on medical education and hospitals to confer on a problem that already has been decided by another department of the A.M.A. —the bureau of medical economics. There is little point to a conference under such unfortunate circumstances.

It is hoped that the appropriate officers of the association will appreciate this inconsistency and will, in fact, consider fully the implications of the Thursday resolution. Some assurance that such will be the case is necessary to restore hospital confidence in the good faith of those who are to make the proposed study.

## Exemption for Hospitals

AN AMENDMENT to the Robinson-Patman Anti-discrimination Act has been passed by Congress to exempt schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for profit from the operation of the act. This is House Resolution No. 8148.

Alert hospitals may find that this exemption will give them greater freedom in purchasing. Probably this will be particularly true of large institutions and those with university affiliation.

## A Suggestion to the A.C.H.A.

NOW that there are several university courses in hospital administration and at least three two week institutes for "refresher" work, a further educational service could be rendered by the American College of Hospital Administrators. It could well consider the possibility of sponsoring instruction in hospital administration on a university level for the benefit of those who are now actually engaged in such work.

In the various population centers in which there would be enough interested hospital administrators, assistant administrators and department heads to warrant it and where, furthermore, suitable faculty members can be recruited, such a course conducted in the evening would prove valuable. If it were to set up proper standards, degrees could well be given to qualified candidates.

The proposed course, to be of maximum service, would need to have a reasonably homogeneous group of students. Because the evening school students would probably be more experienced than those ordinarily attracted to undergraduate or graduate work, a survey type of course probably would be most appropriate. Naturally those who work during the day usually

must take their educational work at a slower tempo.

The body of instruction material available for use in such a course is increasing as a result of the other courses now being offered and because of the formation of the hospital administration library at the University of Chicago. The time is ripe to consider such an educational development.

## Hospitals on the Offensive

THE National Health Conference, which met in Washington July 18 to 20, revealed a striking contrast between the positions of the official hospital representatives and the official representatives of the American Medical Association.

The latter, very early in the conference, put themselves on the defensive. They clearly indicated that, while they doubtless would be forced by the power of public opinion to yield ground, they would do so grudgingly and unsympathetically. Repeatedly during the session the A.M.A. was vigorously attacked for its conservatism. These attacks came principally from the consumer representatives although some gentle chiding was given also by liberal members of the A.M.A. itself.

There were no attacks on the hospitals or their representatives. They did not have to apologize, defend or explain.

The hospitals could point with pride to the fact that more than five years ago they endorsed the idea of hospital care insurance. They could report that already more than 2,000,000 persons are protected by it. They could predict with reasonable confidence that by 1942 probably 10,000,000 persons will be so protected. Mention of "high costs of hospital care" did not infuriate them.

As hospital representatives we may, and probably do, disagree somewhat with the technical committee in assessing the ultimate value of hospital care insurance. We see greater potentialities in this type of voluntary self-help than they do. But whether 20 per cent or 30 per cent or 50 per cent of the entire population can ultimately be enrolled in such plans is, after all, a matter of degree not of principle.

We have always admitted freely that the hospital care insurance plan does not constitute a panacea. We have always acknowledged that it leaves out many important parts of medical costs. We have ourselves pointed out that it makes no provision for the indigent, for the casually employed and for certain persons who cannot be organized into premium paying groups.

We are now in a strong position to ask that, in any plan of health insurance or public medical service, a proper place be left for hospital care insurance plans. When we offer a partnership between voluntary and government action we are welcomed and respected. Our record is good.

It will obviously take some time to develop health insurance or public medical services. In the meantime hospitals should bend every effort to extend sound hospital care insurance plans as far and as rapidly as possible. This will develop experience and data of value in any broader program. It will serve as a training ground for a new type of administrator in the health field. It will promote habits of cooperation among representatives of the hospitals, the medical profession and the public — and the public can no longer be ignored in planning health services. Last but not least, it will give a partial but needed protection to hundreds of thousands of our people.

Good voluntary hospitals and good voluntary hospital insurance plans will always have a place in American life. We can look forward with confidence to their development side by side with any other plans proposed at the National Health Conference.

## Fabian Practices

IN ANCIENT history Fabius was so highly skilled in procrastination that to this day his name signifies a willful failure to make decisions and to act promptly upon them.

In hospital work his spirit still actuates those who postpone making diagnoses or prompt application of treatment. If the intern delays, he may add days to the stay of the ward patient. If such needless expense to the patient and to the hospital could be avoided, hospital deficits certainly would shrink. Because he fears to make a diagnosis that may be checked by a postmortem later, the physician will not record his conclusion on the chart. Only the surgeon who is inclined to be rash causes more danger to the patient than the one who practices to excess the policy of watchful waiting.

For example, a ward patient develops an acute abdominal pain at midnight. The intern, sensing danger, notifies his chief. Fatigued with the day's work, the surgeon promises action in the morning. The intern, knowing that a perforated duodenal ulcer shows a 25 per cent mortality if operated within the first six hours and that hourly thereafter the death rate increases by 10 per cent, is in a dilemma. There must be someone in authority to whom he may go and who will order action at once.

The American College of Surgeons has done much to improve the surgical treatment of patients. The American Hospital Association has contributed largely to the structural and administrative angles of hospital work but the crux of the whole situation lies neither in the presence of good laboratories, ample x-ray departments and an organized surgical staff, nor in splendid buildings and well-trained hospital executives. These all tend to good hospital care. The essential point is whether or not there is somebody at hand to assist the intern in handling a patient at the midnight hour or

to give prompt surgical assistance no matter what the hour or day.

There are six-day-week hospitals in which inexcusable matters transpire on Sundays and holidays. There are those that function well during daylight hours but which are inefficient after nightfall. The 24 hour hospital is one in which the administrator not only practices the teachings of the American Hospital Association but in a measure observes many of the surgical and medical precepts of the American College of Surgeons. Fabius has no place either in the office of the hospital superintendent or on the institution's medical or surgical staff.

## The Administrator's Psychology

SOME executives are content if they hold their positions and receive their pay checks from month to month. They seem to feel that their chief aim in life is to retain their places at all costs and thus avoid personal administrative danger.

Such persons avoid taking sides with anyone. They wait to see what institutional faction will win in a controversy or whether local elections will go for or against the present administration. They avoid the active support of a department head for fear such a policy will be unpopular. They allow morale to be lowered because key persons believe that they will not be supported in taking any decisive action on disciplinary matters and, hence, in a crisis, fear to be firm.

All executives, however, are not members of the mollusk family. Some would risk their positions to defend and support a department head once they are convinced that he is right. Subordinates look up to such a man. They pity the type first described.

It is cowardly for an executive to sit smugly within his office and allow splendid and conscientious department heads to shift for themselves. Such spineless executives should seek some other means of livelihood.

## Problem in Discipline

THE current controversy in the field of labor *versus* capital, carried over into the hospital by an inconsiderate group that has not yet learned that it cannot safely increase hospital expenditure without contributing a financial quid pro quo, has produced a number of unfortunate effects. Time, which heals all wounds, will doubtless heal this one, too. The hospital administrator need not yield to pessimism on this score. Sooner or later a balance will be struck and the controversy will be adjusted. Meantime, however, the transition period presents a problem in discipline that hospitals must face.

Whatever the merits on either side of the controversy, the patient must be served first and foremost. On this point there must be no debate. Until further notice, the governing authorities are in control and the administrator who represents them must see that justice is done, bearing in mind that the patient is his primary concern. Instructions concerning the care of the patient must flow from the governing authorities and from no outside source.

The hospital has the right to expect that, in addition to the usual qualifications of education, character and personality, an applicant for employment be in full possession of a sympathetic attitude toward the sick. Indeed, it is not unreasonable to extract a promise from him that he will never, under any circumstances, abandon his patient summarily to further his own comfort. Hospitals are essentially philanthropic, regardless of whether the bill is paid by the voluntary contributor or the taxpayer.

These thoughts are stimulated by a tendency, which has manifested itself in a number of hospitals, for employes to take orders from agencies not immediately connected with these hospitals and having a purely economic objective as their final goal. Hospital administrators must, with sympathy, understanding and courage, face this new problem that has been thrust on them. Otherwise, the patient may be the immediate sufferer. The prevailing system under which our hospitals are administered does not permit of a division of authority and this is particularly true in the matter of discipline.

## Bookkeeping Methods

SOME executives fail to recognize the advantages of conducting institutional business on an accrual basis. Smaller institutions particularly are likely to adopt a purely cash plan in keeping accounts. Expense items are employed in computing hospital costs only when the bills are paid, not as the goods that represent the expenditure are used. Income is considered as earned only when payment is received.

As a result of this practice no true mean of hospital costs and receipts can be computed from month to month and no accurate unit costs can be obtained to predict the experiences of the future in the light of those of the past.

Such loose methods resemble the procedure of the small merchant who knows his gain for the day only by counting the money that remains in the till after he has paid his pressing bills to those who supply him goods. Moreover, an annual statement for the board by an executive of this type is misleading because it shows only the cash received and the amount of bills paid and not the total amounts receivable or payable. A good business is one that has an efficient bookkeeping system. The corollary of this statement is often equally true: a good bookkeeping system is inclined to result in a sound business.

# "Open Door" Policy in

WINIFRED McL. SHEPLER

INCREASINGLY aware that grievances are expensive, that they cause inefficient work performance to the detriment of the patients, that they are a major cause of a high labor turnover and result in the loss of valuable time spent on daily irritations, Cleveland City Hospital has established the handling of them as a function of the personnel office.

This department, which has a staff consisting of a director and a secretary, is located in the administration building at some distance from the wards. The door is always open. It has been interesting to watch the mounting number of employes who find their way there to bring some problem, to register a complaint or just to pay a friendly call.

The superintendent has made it clear that all employes are free to come to the personnel office at any time. Those in subordinate positions may come without being accused of disloyalty to their supervisors. The theory behind this policy is that a grievance expressed to someone at headquarters may be alleviated just in the telling. Department heads and supervisors are encouraged to come in and discuss their problems as well. Centralizing the receiving of complaints enables the personnel department to locate certain friction areas and furnishes it the necessary information on which to base desirable changes. Gossip is discouraged.

The first lesson to be learned in dealing with employe grievances is to avoid having them by having some staff member always available, approachable and willing to listen understandingly. The "open door" is essential.

In considering the sources of employe grievances we might well ask ourselves, "What do our employes think about us as employers?" The old era of the desk-pounding executive has passed. The modern executive is primarily a teacher, a leader who inspires others and shares with them the glory of accomplishment.

Can we honestly say that our hospitals are entirely purged of the desk-pounders, of the department heads who lurk impressively behind a desk issuing orders, aloof, remote and indifferent to the workers' problems? While we are "breaking in" our employes, aren't they just as truly breaking us in? The executive of a social agency tells a story about the woman on relief who said to her visitor, "Oh, I do hope they won't transfer you to another district just when we've got you broke in so good!"

### When to Reprimand

A grievance frequently expressed by employes is "getting bawled out in front of people." If it is necessary to reprimand or criticize the work of an employe it is only common courtesy, as well as more effective procedure, to do so out of hearing of others. The rage and resentment created by the humiliation of a public scolding may seriously affect work performance for days. Criticism should always be constructive, by suggesting how the error in question may be avoided next time. The personal dignity of subordinates should be respected and preserved by all those with supervisory powers. No one should ever be belittled, not even the humblest worker.

Joe, one of our orderlies, who gets rattled when nagged by an exasperated supervisor but who responds readily to tactful leadership, explains, "When a nurse cooperates with a fellow she don't have to tell you what to do, you just go around looking for things to do!"

Trouble was brewing in a department, the head of which is a capable intelligent man, with considerable experience in handling people. He had sent for a new employe in the course of an investigation into certain practices that he suspected were slowing up the department work. The new employe was bothered by the ethical question, whether or not to tell the truth and involve another employe who was hated and distrusted by all the others. After talking it out in the personnel office he decided that since his "boss" had sent for him and he was not going to him voluntarily to "squeal," he would answer any questions asked of him to the best of his ability.

The matter was cleared up skillfully by the department head who does not know yet that the employe came to the personnel office to think out loud. Had this same situation occurred in a department in which the head was known to be tactless, the personnel office would have guided the employe's thinking along wary lines, on the theory that his frankness might create further havoc. It is important for the person responsible for handling grievances to be familiar with the temper and personality of those in supervisory positions.

### Worker's Attitude a Factor

Next in importance is the attitude of the hospital employe to the job itself. We should know, for instance, what he thinks about the working conditions, the hours, the wages; what compensations there are in the job other than monetary, if any; what there is about the job situation which he resents or considers unfair.

Margaret, a pantry maid of sixteen years' service, complained about the change from two half-days off each week to a full day off in every seven. When the new labor law was explained to her, she commented, "My, I'm glad I came in here. Now I can sleep at night!"

Then there is Katie who came in to complain that she had strained her side lifting things and just couldn't stand the work any more. As her rather slight build was not exactly suited to the wear and tear of the particular job, Katie was assured that a transfer would be arranged as soon as possible. Later the opportunity for the desired change occurred. But Katie had changed her mind; she

# Personnel Relations

## RULES FOR HANDLING EMPLOYE GRIEVANCES

1. **Maintain an "open door" through which employes may gain access to someone in authority to discuss their grievances.**
2. **Make sure that employes "are satisfied with the boss."**
3. **Take time to explain policies.**
4. **Make use of transfers before considering discharge.**
5. **Praise good work generously.**
6. **Remember that employes are people with personal problems that may affect their work.**
7. **Discharge an employe only for "business expediency" and part with him in a spirit of well wishing.**

didn't want to leave a position where she got Sundays off! The mere fact that she was given a choice in the matter removed all resentment.

Jim, an orderly with an enviable record for promptness and reliability, had such regular habits that any deviation from his established routine constituted a major calamity. Jim came to the office upset because he had been transferred from day to relief hours. However, we discovered that it wasn't the change of work to which he could not adjust himself but the fact that the new arrangement upset the habit of smoking three cigars between 7:15 and 10 o'clock every night!

Jim's problem was real to him. When an appreciation of the sacrifice that he must make was expressed in all sincerity, Jim left, apparently content to accept the rôle of martyr, as "the office" recognized him as a sacrificial victim to our system.

There is not much glamor in most of the routine jobs in a hospital. Much of the work is drab routine and salaries are low. What compensations, then, can we arrange to supplement these poor returns for effort? Adequate meals are a necessary compensation, restrooms for those on split shifts are essential and living quarters should be as homelike as possible. Problems arising from unsatisfactory living conditions may be acute.

Miss Prudence Parker, aged 61, who is employed in the hospital sewing room, lives in the dormitory. When her roommate left our employ, a successor, fat, jolly, capable Annie Janowsky, a merry widow of 30, was moved in with Miss Prudence. Annie loves fresh air; Miss Prudence loathes drafts. Annie likes a cigaret or two while she reads murder mysteries; Miss Prudence was outraged. And the quarrel was on! Immediate separation was the only answer before murder would result.

For some reason hospital work is especially attractive to those of the "introvert" type who derive satisfaction from the paternalistic nature of the institution which provides shelter, food and companionship and, which in many subordinate positions, requires little initiative or aggressive behavior. Psychologists tell us that the introvert responds intensely to praise and will put forth more effort for appreciation than for pay. Robert Hoppock points out that "self-esteem means more to most individuals than money" and suggests the wider use of praise as an incentive with vast possibilities of increasing human effort. However, he warns that praise must be used with discretion; "Never praise the man himself, praise his work. . . . If you praise his work you focus his attention on it and give him an incentive to do equally well or better next time."

Sadie, feeling disgruntled because she was transferred, was mollified when told that her work had been excellent and that she was needed in the new location. Fred, our "problem child" of the porter group beams and works harder for a while when told that his work is "improving."

If we are to be happy and well-adjusted to our work it is necessary for each of us to feel important. Christopher, the hall porter, pokes his head into the office, and comments, "You know, Ah think y'all studies yo' mind too much." We agree and suggest that we change jobs for a time, Christopher to work in the office while we go out and polish brass and mop.

Christopher looks embarrassed, scratches his head and replies gravely, "Well now, Ah don't hardly think y'all could do my job!" It is the responsibility of the hospital authorities to teach this sort of job loyalty.

Many problems associated with the job itself may be solved by taking time to explain policies, by transfer to new work and by the use of praise and commendation.

Grievances that may appear to be related either to the employer-employe relationship or to the job itself may be in reality caused by some difficulty in the employe's life situation outside of the institution. Friction at home may be carried over into the job with devastating results.

Hospital employes are, first of all, people — human beings, usually with families, homes, anxieties and budgets. Perhaps we cannot be our brother's keeper to the extent that we assume case work responsibility for him, but surely we must be alert to personal problems that affect the efficiency of our workers.

It is important that the personnel worker should be thoroughly familiar with community resources and should know what to suggest when an orderly comes in panic stricken because his wife is ill and there is no one to care for the children; when a cleaning maid wants information about aid for a paralyzed grandparent who has arrived in the home

to share her meager earnings, or when a frantic pantry girl wants immediate medical care for her husband suddenly taken ill at home before she had to leave for work.

The simple phrase, "All right, suppose you let me worry about that today, and I will see you before you go home tonight," has kept at his task many a worker who might have given up in despair.

Lena, a ward maid, strong, capable and fun-loving, came into the office and sank down into the chair by the desk, the picture of defeat. The conversation was something like this:

"Well, Lena, how are things going with you?"

"Not so good — I dunno — I just can't work any more. You know things aren't so good at home."

"Would you like to talk about it?"

"No." There is a fight to keep back the tears.

Seeming to change the subject after a little pause, but conscious that a longing to "talk about it" was what brought Lena to the office, the personnel worker inquired, "How are the children?"

### Providing Emotional Support

Then the whole grim story came out: an irresponsible, unfaithful husband and three demanding children, all are dependent on Lena who "can take it" physically but is obviously in need of emotional support. A chance to talk it out lifted the burden and Lena gratefully accepted referral to a social agency equipped to provide the necessary emotional support and to help plan for work and leisure time activities for the children. Lena looked at the clock and dashed out, back to the work she had felt she just couldn't do any more, exclaiming, "Gosh, I better hurry or I'll be late on the floor."

The personnel worker also must be experienced in recognizing the signs of mental illness. Edna, an unattractive woman of 47, accused another maid of going out to meet her "boy friend" and complained that the painters in the building were talking about and laughing at her. Edna must be regarded not as a trouble-making employe but as a sick person seriously in need of psychiatric help.

The realization by administrators that employes' work may be affected by personal problems has saved many a valuable worker for an organization.

In a symposium entitled, "For Top Executives Only," an experienced administrator of Big Business gave the following formula for separations from service: "Do not 'fire' an employe; part with him with regret, delicacy and personal good wishes; for on strict organization principle you are to blame for all failure among subordinates. Also, it is poor sportsmanship to break a man's morale in this way."

Another rule of executive etiquette given in this volume is, "Do not fail, if it is necessary to discharge or deprive workers of authority, to do so on the basis of business expediency rather than on personal failure."

Rosie, an appealing, childlike girl of 20, was driving her supervisor frantic because she could not learn the kitchen routine after months of patient teaching. A check of her school record by the personnel office disclosed that Rosie was below par mentally and misplaced in her present employment.

The nurse in charge of her division had discovered that Rosie had a flare for hairdressing and had been turning out the pantry maids to look like movie stars. This information was passed on to the social worker in charge of relief for Rosie's family, with the suggestion that the girl might capitalize on this talent, under strict supervision. Before Rosie left our employ the social worker was prepared to adjust the family budget accordingly and was trying to plan a more suitable placement for Rosie.

Old Harvey, a pillar of the institution, was growing so old and feeble that he could no longer serve his beloved patients well. For weeks before his discharge a plan was carefully made to ease him out of service as painlessly as possible. During several interviews at the personnel office he was first urged to think about the time when he must stop work, then informed of the provisions of the Aid for the Aged, persuaded to "look into it" and finally sent with a letter of referral to apply. So that when Harvey finally left us he was not a bitter heartbroken old man, forced out of a job, but a faithful employe gracefully "retiring."

The next time it is necessary to "part with an employe," with or without regret, let us ask ourselves, wherein did we fail with this person? Was it poor selection in the beginning? Have we tried to teach him, encourage him and, through leadership, give him a chance to make good? Have we given him an opportunity to voice his opinion of his job situation? Has he been hampered by personal problems? And, finally, let us ask ourselves, "What will this employe do next?" If we are unable to absorb him into our organization, can we suggest some other job where he might succeed?

### The Ultimate Grievance

The grievance surpassing all grievances is that which is occasioned by the involuntary loss of a job. The explanation that a certain type of work "just wasn't the job for you" has saved many an employe "face" and sent him out hopefully to seek "the job for him." Such an attitude builds up for any institution a reputation for fairness and gradually a superior type of employe is attracted to it and stays.

Cleveland City Hospital's personnel program already is proving valuable to the institution in gradually helping to build up a more contented and efficient working group and, as a result, a more permanent staff. Department heads have commented voluntarily on the smoother performance of their divisions as a result of transfers, carefully selected replacements and the handling of grievances by the personnel office. The head of one large department in which there has been some serious friction reports that the employes there are developing unprecedented teamwork.

Some of the credit for the improvement in attitudes is graciously attributed to the activities of the personnel office. Supervisors are conferring with the department more and more in problems involving the employes. This pooling of information and of points of view is proving invaluable in the working out of intelligent plans for a finer and more effective organization and for consequent improved service to the patients.*

*From a paper presented before the Ohio Hospital Association, Columbus, April 1938.

# Six Years in Public Relations

M. H. EICHENLAUB

SIX YEARS have elapsed since an organized public relations program was undertaken by the Hospital Association of Pennsylvania. The beginning was in the summer of 1932. At that time an emergency had arisen or it might not yet have been established. The need had existed previously but hospitals had not acted. When the step was taken, it had become a matter of utmost necessity.

This united effort has been broadly educational in purpose. It will be continued on that basis, since the specific services of hospitals and their special rôle in the community need to be explained. Hospital finances ultimately can be improved by thoughtfully informing the public.

At times the definite objectives have been of an emergency character. The original crisis that brought about the public relations program was a serious threat to practically one-fourth of the state aid that the hospitals were then receiving. The actual beginning was made in June 1932 for sixty days, to forestall this economic disaster. Because this move was so swiftly successful the entire setup was renewed and continued in September 1932 by vote of the board of trustees of the state association. Following the first emergency, two other state aid emergencies were dealt with, the last being a statewide campaign to pass a $25,000,000 relief bond issue in which part of the hospitals' state aid, amounting to $2,231,365, was held in suspense.

The mediums used have been principally the newspapers, occasionally the radio, a few meetings and a limited amount of printed matter.

The cost has varied. In the main the program has been operated on from $6000 to $8000 annually, but expenses increased to $10,000 last year, most of the sum having been contributed by the supporting hospitals. It has meant basing charges to the individual hospitals according to bed capacity and also according to whether or not they were state aided institutions. The assessments have ranged from $1 for a nonstate aided hospital of less than 50 beds to $22.50 for a state aided institution of 700 beds. A large part of the expense has been for the full-time services of a professional writer, the remainder going for clerical hire, office supplies, mimeographing of news releases and postage.

As for results, we can speak only as individuals. The committee is satisfied that the economic safety of the voluntary hospital has been conserved by the educational campaign, that it probably should have been started earlier and that it should be continued.

We will not burden you with a full recital of our objectives, which are mainly economic. Pennsylvania is now divided into five regional zones for the sake of closer contact and better coordination. A few of the planned activities for the coming year may be of interest:

1. To effect a closer contact with all regional groups for the stimulation of publicity in each region.
2. To plan a sustained radio program over every station in the state that will work with local hospitals.
3. To stimulate and to assist as far as possible in arrangements for talks

**Examples of effective publicity mediums are a hospital paper, news feature, pamphlet and editorial.**

WEST PENN NEWS

PITTSBURGH, PENNSYLVANIA

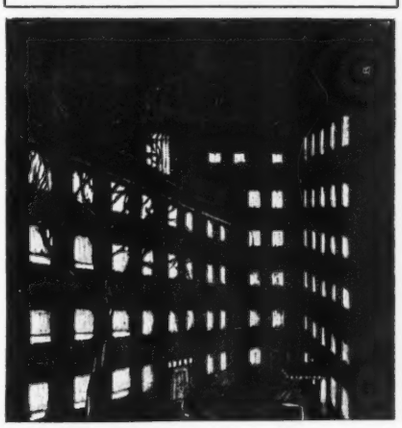
**The Hospital**

**The Vasculator**

**To Our Readers: This Issue of the News is the Product of Peabody High School's Editorial Staff**

From Hospital Association of Pennsylvania
M. H. Eichenlaub, Publicity Chairman
Pittsburgh, Penna.

## A HOSPITAL AT NIGHT



NOTHING is more stimulating to the imagination | bulance slips away, leaving its wounded cargo. Soft-footed

## THE FOLLY OF DELAY

**Can We Afford to Ignore the Definite Warnings of Disease?**

**THE same man whose brow furrows at the first sign of a wrist-pin knock in his new car ignores the warnings of that delicate living mechanism . . the human body . . which must carry him all his mortal days.**

**To escape aches and pains which hamper his pleasures and work, he embraces any "cure-all"**

*(Editorial in Pittsburgh Sun-Telegraph Monday, October 9, 1933.)*

## Help the Hospital!

**Charity and Good Business Judgment Demand That the State Shall Come to Their Rescue.**

The 8-year-old son of a foreigner, a workingman in very humble circumstances, was taken to a Pittsburgh hospital recently in a critical condition from tetanus, the result of running a dirty splinter into his hand. By a liberal use of antitoxin the boy's life has been saved. The serum cost the hospital $152.40, and it is doubtful if the child's father can pay for it. Who, then, is to pay?

Let us consider a more common demand on the hospitals. Someone dangerously ill from pneumonia is rushed to a hospital. The physicians direct that oxygen shall be given. The patient is put in an oxygen tent and the gas administered. A serious illness of two weeks duration probably would cost the hospital at least $70 for oxygen alone. Suppose the patient is indigent—who is to pay?

The hospitals of Pittsburgh and Pennsylvania have had to take care of innumerable cases like this—expensive cases—cases in which the patients have been unable to pay. And the result is that many of the hospitals have been brought to the verge of bankruptcy.

The general hospital in Rochester, Pa., recently found itself in such desperate straits that it had only two dozen eggs on hand and needed 15 dozen to take care of the patients' requirements for a single day. It sent out an SOS call, which brought it baskets of eggs and provisions. But what a shame.


**An impressive collection of clippings that shows how the Hospital Association of Pennsylvania is educating the public.**

before clubs and other organizations.

4. To initiate in printed form a series of educational leaflets dramatically portraying hospital services, these to be offered to interested hospitals at the lowest possible pro rata cost for wide distribution.

5. To induce additional newspapers to use the association's "It's a Fact" series, jointly with local hospitals.

6. To prepare publicity for specific groups whose support the hospitals need and who should be told the story of what the hospitals are doing.

7. To bring home to members of the legislature, among other groups, the problems of the hospitals, even when no emergencies are present.

8. To assist in obtaining passage of a law reimbursing hospitals for losses resulting from automobile accident cases.

9. To effect better understanding between hospitals and their medical and surgical staffs in educating and serving the public.

The program was launched upon its new fiscal year on June 1. Eight members were selected to serve on the public relations and publicity committee during the current period: Dr. Donald C. Smelzer, Mary V. Stephenson, H. E. Bishop, Jessie J. Turnbull, Col. Percy L. Jones, H. L. Mason, H. S. Mehring and M. H. Eichenlaub.

# Chronically Ill and Aged

## Standards for Care of These Patients

MARY C. JARRETT

CHRONIC illness occurs more frequently among the aged than among younger persons. This report is concerned primarily with the institutional care of the chronically ill and aged. They now receive care in institutions of three types: hospitals, homes for the chronically sick and homes for the aged.

Homes for the chronically sick are designed to care for patients who, although they cannot be benefited by further active medical study and treatment, require nursing or attendant care under medical supervision and should have homelike quarters, occupation and recreation.

Homes for the aged, as a rule, do not admit persons who are incapacitated by illness; but when illness develops after admission, most of these institutions endeavor to provide medical and nursing care for any condition that does not require hospitalization.

A few of the private homes for the aged gradually have added to their facilities until in their equipment and in the character of their medical service, they resemble institutions originally designed for the care of the sick and the question is raised whether they may properly call themselves "homes" or "hospitals" for the chronically ill. As their facilities for the care of the sick are increased, homes for the aged show a tendency to be less insistent upon the requirement that those admitted shall be without physical disability and several homes have a definite policy of admitting some chronically ill persons.

### Function of Homes Changing

Many who are interested in the care of the aged believe that the operation of old age security laws will keep more of the able-bodied aged in their own homes and that homes for the aged in the future will, therefore, find their function to be more and more the care of the chronically ill. However, there is no conclusive evidence to substantiate this view.

The Hospital Survey for New York recommends that "some of the voluntary homes for the aged might well consider using all or part of their institutions for the care of the chronically ill of the custodial group in the middle and late years of life. For this purpose, the age requirement for admission should be lower than the usual age limit of 60 years. Homes for the aged under voluntary auspices could then be used more extensively for city charges, under conditions formulated by the department of hospitals." Such homes naturally would be differentiated from the usual type of home for the aged without special provision for the admission of chronically ill persons.

**The report on the care of the aged and chronically ill by the New York Welfare Council shows a need for custodial care of the chronically sick in public and private institutions**

If this should be the trend, it seems probable that homes for the chronically sick would, in turn, receive a larger proportion of the more seriously disabled chronically ill, particularly the bedridden and those who require skilled nursing, so that more and more they would come to resemble hospitals and their function would be more and more likely to be confused with that of a hospital.

In view of the possibility of this trend, the section on the care of the aged and the committee on chronic illness of the Welfare Council of New York appointed a joint committee to clarify the situation in regard to the three following points:

1. A method for classification of homes for the aged, according to the type of care they are equipped to give the chronically ill.
2. Requirements with which an institution that desires to become a "hospital" should comply.
3. The special function of homes for the chronically ill and the standards with which they should comply.

In classifying homes for the aged according to their facilities for the care of the sick and the type of medical and nursing care provided, the committee recognized that it was impossible to apply a rigid classification to these institutions. These homes fall into three large groups:

The first group has such facilities for the care of the sick as might be provided in a private home. Medical care is furnished for the individual patient as needed either by the institution itself, by other agencies or by relatives. Some patients with chronic conditions not requiring hospital care can be given all necessary attention in this way. Some of these homes maintain a special section for the care of the sick.

### Nursing Care Is Provided

The second group includes homes providing nursing care under the supervision of a registered graduate nurse assisted by male and female attendants, dietetic facilities sufficient to meet ordinary needs and to provide diets suitable for diabetics or others, regular visits by a physician with the opportunity of calling on consultants whenever needed, adequate medical records, periodic physical examinations of all residents and some laboratory facilities.

The third group includes homes providing registered graduate nurses, complete dietetic facilities, complete diagnostic and therapeutic facilities

and equipment, at least one resident physician and regular visits from a staff of attending physicians and surgeons. In this group are a small number of homes that desire to specialize in the care of the aged who are chronically ill.

In the third group are homes for the aged that desire to be rated as hospitals. The committee feels that the term "hospital" should be strictly limited to such institutions as comply not only with the letter but also with the spirit of the requirements laid down by the American Medical Association and the American College of Surgeons. Whenever a home for the aged has arrived at the point at which it believes it is qualified for the title of "hospital," it should apply to one or both of these organizations for an official inspection and rating.

For the care of the chronically ill aged, the second type of institution fills the largest need. If located within a short distance of a large general hospital and staffed by capable medical men, it is in a position to give complete medical care to all of its patients.

### Not Equipped as Hospitals

Homes of the first type obviously do not regard the care of the sick as a primary function, but when sickness occurs the patients receive individual attention.

Homes for the chronically sick are not equipped or operated as hospitals and are listed in the hospital classification of the American Medical Association as "related institutions." Their admissions are not confined to the aged, but the type of care they provide is similar to the care given in homes for the aged of the third group described above. A majority of chronic disease patients requiring institutional care are not in need of hospital service. It has been estimated that for every chronic disease patient needing hospital care, there are three chronically ill persons needing custodial (or domiciliary care) in related institutions for the sick.

The ideal situation is a homelike custodial division attached to a hospital for chronic diseases, but such hospitals are still rare and independent custodial institutions are in demand. Policies in regard to the type of patient admitted to such institutions have not been formulated and standards of practice in regard to equipment and medical, nursing and social service have not been drawn up.

One of the recommendations of the Hospital Survey for New York is that "the present policy of the department of hospitals of paying for destitute chronic disease patients in voluntary institutions should be continued, and it should be systematized so that the department may be assured that the institution admits only the type of patient for whose care it is equipped and that it gives a type of care suited to the patient's needs."

### Regulations Are Outlined

Regulations governing the admission of city charges to voluntary institutions caring for the chronically sick and the infirm aged have since been formulated by the department of hospitals. In community planning for the chronically sick, the needs of paying patients also should be given special consideration.

A large increase in the number of beds provided for institutional care of chronic disease patients of the custodial group may be expected in New York City. Undoubtedly there is great need for increased facilities of this type, although no accurate estimate can be made of the number of additional beds needed until more is known about the possibilities of home care and the prevalence of incapacitating chronic illness.

The Hospital Survey found nearly 10,000 beds in New York City available for chronic disease patients in 1935, exclusive of those with tuberculosis and mental disease, of which less than half, about two-fifths, were for custodial patients and about three-fifths were in hospitals.

If the estimate that three times as many custodial beds as hospital beds are required for the chronic sick is correct, then along with the existing 6000 beds for hospital care should be 15,000 to 18,000 beds for custodial care, instead of the existing 4000 beds found by the survey. However, it is likely that nearly a sixth of the hospital beds are used for patients who need only custodial care. It remains to be seen what effect better provision for home care of chronic disease patients will have upon the demand for institutional care.

In the Welfare Council's study of chronic illness, it was estimated that 2000 additional custodial beds were needed to provide proper care for the chronically ill persons already known to welfare agencies. Further evidence of the demand for increased custodial provision for chronic disease patients is found in the reports collected from social agencies by the Welfare Council for the Hospital Survey for New York, regarding inadequacies of service for care of the sick in the city.

There is a demand for a large number of additional custodial beds and it seems probable that the public consciousness of the needs of the chronically sick awakened in this country during the last few years in New York and elsewhere will result in enlargement of old institutions and building of new institutions. It is important that these new developments should be founded upon sound and comparable principles of administration. It is correspondingly important that the public should understand the function of institutions of various types and the services that may be obtained from each type, in order that the chronically ill may receive the benefits they afford as promptly and efficiently as possible.

### General Requirements

The committee has attempted to outline the general requirements for custodial institutions for the chronically sick in regard to admission policies, medical facilities and staff for medical, nursing and social service, as follows:

Every patient before admission should have received sufficient medical and social study to show that improvement of his condition could not be expected through active medical study and treatment, such as he would receive in a hospital and that institutional care, rather than home care, is best suited to his situation.

Patients should be cared for in separate rooms or cubicles or in small wards of not more than six to eight beds. Adjustable curtains should be provided to screen off each bed. Each ward or group of rooms should be provided with a service pantry, nurses' utility rooms and lavatory

facilities and each group of wards, with a sitting room for ambulatory cases. There should be isolation rooms for the acutely ill or for those suffering from a contagious disease.

In addition to the central kitchen, there should be a special diet kitchen in charge of a trained dietitian for the preparation of special foods as ordered by the medical staff.

Offices and examining rooms for the use of the medical staff are essential and, if possible, should be grouped with the record room and laboratories.

A comprehensive individual record system, covering the admission data and all subsequent observations on each patient, is indispensable. It might be desirable for institutions of this type to adopt uniform record blanks. The care of the records should be entrusted to a trained worker under the supervision of the medical and administrative staff.

Laboratories should be provided for clinical microscopy and the simpler chemical tests of the body fluids. Equipment for diagnostic x-ray work is desirable. Equipment for electrocardiography and the determination of the basal metabolic rate is not essential but would often be helpful.

A physical therapy department should be completely equipped with all modern devices for such procedures. Space also should be set aside for the use of dentists and for other special services. Whenever possible, a necropsy room, adjacent to the morgue, should be provided, with suitable equipment.

Occupational therapy is an important feature of institutions for the chronically sick. Special provision in the way of workrooms and storerooms is necessary. Facilities for recreation should be provided.

Space must be provided for the storage of drugs used in the institution. The services of a registered pharmacist are not necessary, as there is little need for the compounding of special mixtures.

The daily care of the inmates should be in the hands of one or more resident licensed physicians who have served an internship in a general hospital approved by the American Medical Association. It should be their duty to examine applicants for admission; to make rounds through the wards twice daily, and to prescribe for the residents under the supervision of the attending staff. They should be responsible for the maintenance of the records and for the performance of such laboratory work as may be required. Periodic physical examinations should be given annually.

The attending staff should be composed of internists who are interested in the problems of chronic disease and who have had experience in caring for these conditions. They should visit the institution at least three times weekly, see all new patients after admission and supervise the diagnostic and therapeutic efforts of the residents.

The consulting staff should include representatives of the following specialties: ophthalmology, rhino-otolaryngology, neurology, psychiatry, general surgery, orthopedic surgery, gynecology, dermatology, roentgenology and dentistry.

The nonmedical trained personnel should include: the dietitian, the occupational therapist, a physical therapist and a laboratory technician.

There should be a registered graduate nurse in charge of a staff of attendants and other graduate nurses as needed.

A trained social worker, with assistant social workers as required, should be in charge of the affairs of patients that involve relationships with the family and community. In particular, she should review the patient's situation before admission with reference to his need for institutional care and from time to time after admission with reference to his return to the community.

These standards apply to an individual self-sustaining institution. Some features may be unnecessary duplication if the custodial institution is attached to a hospital.*

*Joint Committee on Institutional Care of the Chronically Ill: Dr. Frederic D. Zeman, chairman; Helen C. Adams; Dr. Moody W. Arnold; Rev. John J. Bingham; Dr. E. M. Bluestone; Susan D. Bliss; Dr. Ernst P. Boas; Rev. John J. Donovan; Beatrice Hall; Isidore Greenspan; Mrs. William G. Lewi; Adolph Lourie; Dr. Jack Masur; Mrs. Charles Perkins; Ollie Randall; Edward K. Warren; Mary C. Jarrett, secretary, Committee on Chronic Illness; Mrs. Alice F. Rothblatt, secretary, Section on the Care of the Aged.

# Protecting the Intern

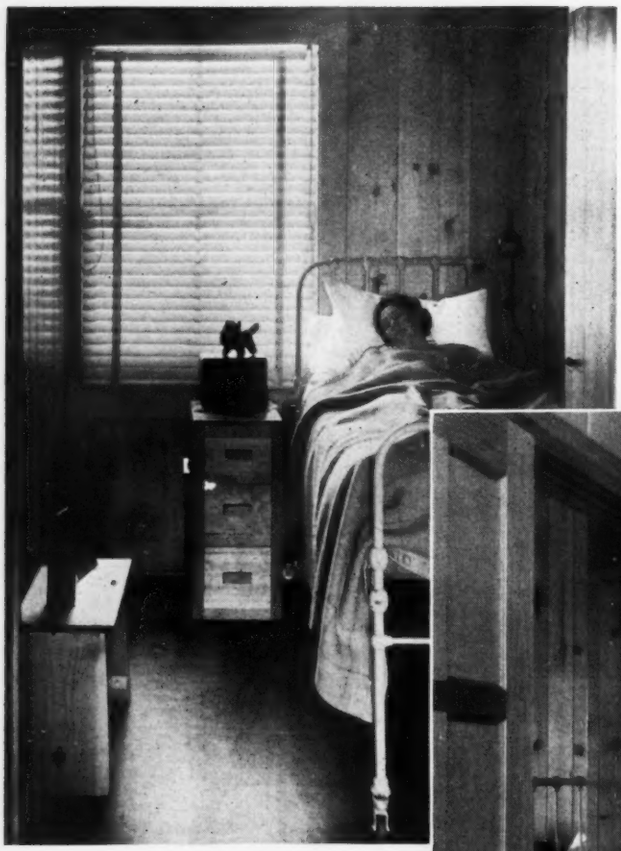
F. STANLEY HOWE

THE large part which the capable and conscientious intern plays in the service of our hospitals justifies every possible consideration that we may extend to him. Now that interns are developing a group consciousness, they are beginning to remind themselves of some of the conditions to which they are subjected and which reflect little credit upon individual hospitals. Since their service with us is in a sense a continuation of their medical training, it should, perhaps, not be put on a merely mercenary basis. This factor, however, does not absolve hospitals from a certain moral obligation to protect the intern in the event of any mishap.

Recognizing this obligation, the Orange Memorial Hospital, Orange, N. J., has for a number of years followed the practice of presenting to each man on beginning his service an accident policy. This policy provides indemnity for bodily injuries sustained through accidental means, such as those resulting in disability, dismemberment, loss of sight or death. The intern names his own beneficiary as he would in insurance taken out by himself. Each policy provides the usual benefits and a principal sum of $5000 in case of death.

The annual premium of $20.80 per man, while small in itself, is more than the average intern would feel he could afford out of the nominal compensation that he receives. The regular compensation insurance for interns as hospital employes, being based upon their very moderate stipend, is wholly inadequate for men who have incurred the expense incident to obtaining a medical education. We believe that a special policy of this kind is the least we can offer them under the circumstances.

# A Sanatorium



**In remodeling the open pavilion partitions were built of knotty pine to form individual rooms (left), each opening off a central corridor, also finished in pine.**

IT WAS our new building that made us conscious of the defects of our old building.

A few years ago the board of directors at Samuel Bowne Memorial Hospital, Poughkeepsie, N. Y., decided to build a new building exclusively for private patients. We had a constant waiting list of patients whom we could not accommodate, patients from Connecticut, Long Island, New York and New Jersey.

The president of our board, Dr. Grace N. Kimball, with the cooperation of Mrs. Samuel W. Bowne, who had given the original hospital as a memorial, decided to build a new building to accommodate this waiting list. The board asked Doctor Williams and me to draw up plans for the new construction.

"Would you like us to visit various hospitals and get ideas?" we asked.

"No," was the reply, "we should like you to plan a hospital in conformity with the present building, inculcating all its virtues and eliminating all its faults. You have lived and worked in this building and you know what the patients need to be happy and comfortable and what the administration needs to function efficiently."

So we set to work to draw up primitive plans which the architect would perfect later. We had many ideas of our own; by observation and questioning of patients we gained more.

Our hospital catered largely to the tuberculous, men and women who must remain in the hospital many months. The new hospital was to cater to all chest conditions, heart and lung patients who also would remain in the hospital for long periods.

The old building had been built in 1911, twenty-seven years ago, in the days when open pavilions with plenty of fresh air summer and winter was the primary thought in planning for tuberculous patients. Our first thought was to give the patient privacy and comfort.

A patient may go into a general hospital for an operation, with an infectious disease or to have a baby, remain for a few days or at most a few weeks, and be well enough to go home again. Hospital living conditions are not nearly so vital to him as to the patient who goes into a sanatorium to live for months. Yet, at the time our building was constructed, sanatoriums had failed to take this into consideration and had planned for many of these patients no privacy at all. A bed in a pavilion and a locker somewhere were supposed to be all that the patient required.

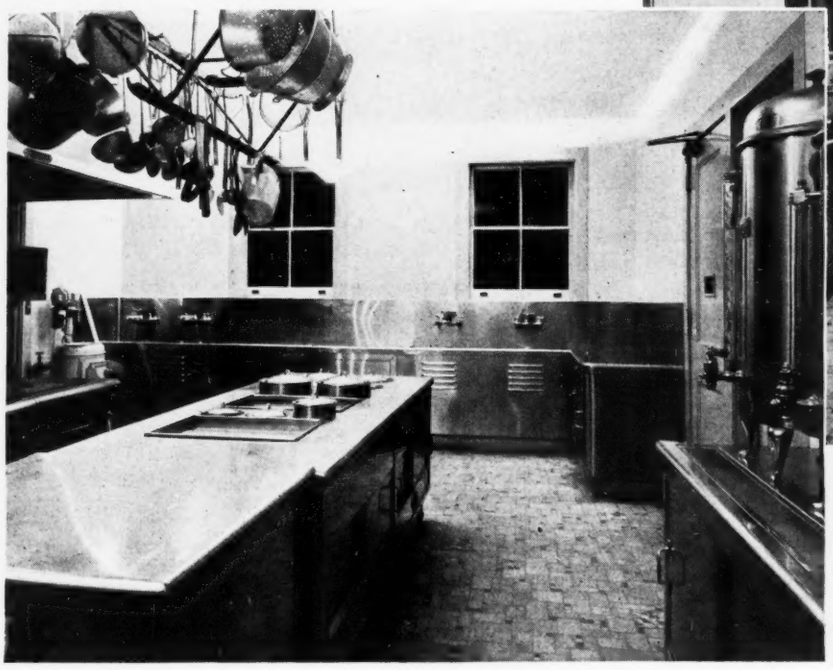
In the years that have passed we have learned that the mental state of the patient has a large bearing on his recovery.

Consequently, the first thing we planned for our new building was a small suite of rooms for each pa-

# Spruces Up

MRS. H. ST. JOHN WILLIAMS

**Kitchen modernization included ivory glass walls, stainless steel sinks and tables, indirect lighting, streamlined cupboards and red and green linoleum.**



tient; a bedroom with plenty of air and sunshine, accessible to a large open porch; a large clothes closet; a dressing room with toilet, washbowl, dressing table and mirror, and a sitting room in which guests might visit.

In course of time our new building was opened and functioning. Gradually there began to grow in our minds a desire to make the old building as attractive as the new.

One of the things that troubled us greatly in the old building was the kitchen. Built in the tradition of a quarter of a century ago, it lacked the appearance of modern sanitation. We found ourselves trying to hide the kitchen.

"It looks dirty, but it really isn't," we would explain, as some newcomer would gaze around at the varnished wood cupboards and wainscoting, the greasy looking galvanized sinks with their open legs under which, it seemed, it was always necessary to shove large pans of vegetables or odds and ends.

We realized that, first, new sinks must be installed and decided on stainless steel units with fronts to the floor and with sliding doors opening on to shelves to contain the ever present pans of vegetables. But these would be too imposing in contrast to the old wooden cabinets and wainscoting.

We knew that we could modernize the whole kitchen at one time to better advantage and at a much lower total cost than by doing it piecemeal. But we hadn't included this job in our budget, and we couldn't spend more than our budget. We took a long breath and plunged. For many months we wondered if we ever would come up for air.

Walls, lighting, floor treatment and cabinets were investigated; trips were made to New York wholesale houses and the architects' exhibit; decorators' magazines were scanned.

Today the modernized kitchen in our 27 year old building is the first room to which we take visitors.

The walls are ivory glass from floor to ceiling and the trim is of soft green enamel. Stainless steel sinks and cabinets with table tops and cupboard fronts are streamlined around three walls, with the gas range set against the fourth wall and a stainless steel serving table in the center. Modern in-built lamps light the work tables and indirect ceiling lights make daylight out of night.

Linoleum in tile design combines the red of the chimney, the green of the enamel and the ivory of the walls.

We were getting into the spirit of modernization. The patients had gained only indirectly from the new kitchen. We desired to do something directly for them.

Among our wards was an open pavilion for ambulatory patients accommodating 16 women. Sixteen women in 16 beds in one room!

**A cheery corner of the employes' dining room. The dresser, designed and installed by employes, contrasts with the vitreous tile wainscoting.**

A dark corridor leading to this pavilion was made darker and narrower by a row of lockers, the only accommodation for their clothes.

Leading from this corridor on the right was a dressing room with three curtained sink compartments which cut off what little light came through the opaque windows. Cubicles with curtained fronts crowded each other around the room. Rows of additional lockers marched out into the center of the room. Each cubicle contained hooks and two small mirrors, which was the sole dressing room space for two women. This was where, in comparative darkness, they powdered their noses and put on their lipstick. Someone had donated an old hall rack which towered and toppled in the center of the room but it did have a good sized mirror.

**Above: Remodeling the old dressing room and (right) a compartment before it was rebuilt.**

A toilet room and a bathroom led off the corridor on the opposite side. The bathroom was gray cement and contained one huge tub. That was all.

We never put new patients in this pavilion. Not until a patient had been with us for a time and realized we were rather nice people in spite of appearances was it possible to ask her to move to these quarters. This was another part of our hospital of which we were ashamed, but budgets always had to be considered.

Our workmen were cooperative; a good carpenter and a good painter were just as interested as we were in improving conditions. And we were inspired by a new idea. Why not tear out the whole interior of this section and, with only the outer walls of the building and the corridors to limit us, build up anew, using our own labor, which would cut costs materially?

I had been down to the Hotel Show in New York and had seen portable showers that could be bought for $25. I think this was the germ of the idea, although we didn't buy these portable showers. But we did decide to begin with the plumbing. We were reminded constantly of that one big tub for 16 women.

There was a large linen closet which we decided we could do without. The linen was moved out and the plumbers were moved in. When we realized that the cost of the shower bath equipment was not as great as the installation, our ideas began to take shape. We called in the tile man. The final result was a bathroom tiled with ivory and delft blue, with two tiled showers and a tub. With one bathroom finished, we went to work on the other, the old gray cement room with its huge tub, and duplicated the first bathroom. Now we have two tiled bathrooms, with four showers and two tubs, for sixteen women patients.

Then we started on the toilet room with its black slate partitions and its two toilets. We pulled out the slab partitions, relocated the toilets to make room for a third, installed

partitions of structural glass which let in light to all compartments.

In the meantime our carpenter had begun work on the open pavilion. We brought down the high open ceiling, built partitions of knotty pine panels off both sides of a 5 foot corridor, which we left down the center of the room. We divided each side into individual rooms of knotty pine. On either side of the room partitions we inset bookshelves which can be reached by the patient in bed.

Our carpenter built oblong stools of the pine, low enough to slide under the bed when not needed and, instead of the typical bedside table, he made narrow pine chests of drawers with table tops.

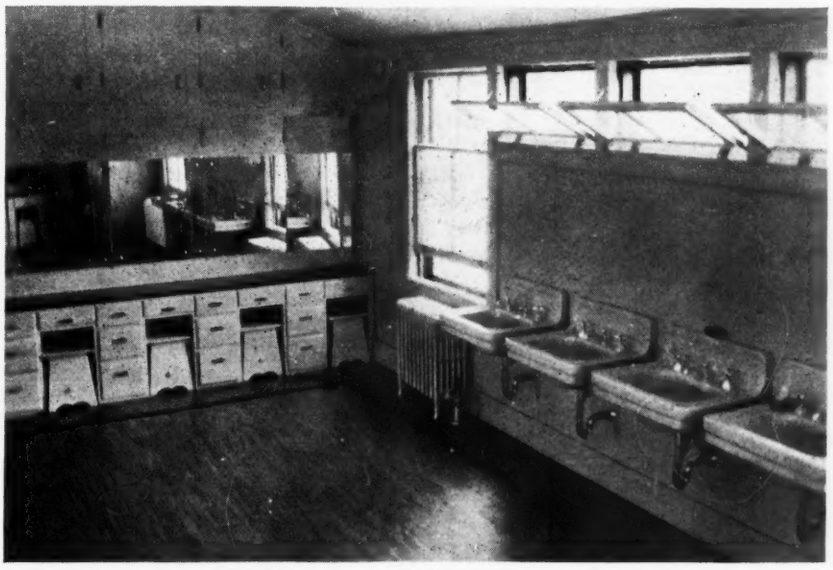
The wood was steel wooled, shellacked and sandpapered, steel wooled and shellacked again and again and finally waxed until it shone and was soft to the touch.

Indirect lighting was installed in the corridor and a delft blue jaspé linoleum in rooms and corridor. Clothes rooms were built in each room and new bed lamps purchased.

All the time an idea had been growing in my mind for the old derelict dressing room. "A chorus girls' dressing room," I was saying under my breath. Now that it is finished, the girls are calling it the Hollywood room.

With the patients' individual rooms finished and their clothes moved into closets and drawers, we took the lockers out of the dark corridor, thus making it about 2 feet wider, and began breaking down cubicles and generally cleaning out the old dressing room until we had nothing left but the outer shell of the room. We kept the opaque glass in the lower sash for privacy, but replaced the top sash and the transoms with clear glass.

Then we began our rebuilding. Still with our own labor, we built around three sides of the room, streamlined, a continuous dressing table top with alternate knee space and drawers, giving each of the girls her own section of the dressing table and drawers. The room was painted in a pastel peach, a tint so soft that it seems an ivory to the casual observer. The dressing table top was of Chinese red micarta, a material I had practiced upon with burning cigarets, alcohol and medications and found that nothing harmed it.



**Two views of the Hollywood dressing room. Note the mirrored doors to the clothing lockers and extra lockers above. Wash bowls are in peach.**

Back and above the dressing table lockers were built in which reached the ceiling and were divided into an upper and lower compartment. In the lower compartment there is room for dresses, bathrobe, night attire and shoes; in the upper compartment, above her own dressing table, the orderly packs away the emptied baggage of the incoming patient.

At last we were giving these patients room enough and to spare. The delft blue jaspé linoleum of the corridors was carried into the dressing room with an inset border of the Chinese red linoleum. Above the dressing tables and against the lockers, we installed continuous mirror glass around three sides of the room. On the fourth wall, between the windows and under the transoms, we hung four peach wash bowls. In one corner of the room a small dressing room for individual privacy, with mirrored door and linear lighting, was built. Indirect ceiling lights were used in the room, giving at night a bright daylight glow in every corner.

Soon the patients in our private rooms were asking to be transferred to the Hollywood ward. What we did with the private rooms will be told in another article soon to appear.

# Hospital Care Insurance

C. RUFUS ROREM, Ph.D., C.P.A.

NONPROFIT hospital care insurance plans resemble stock or mutual insurance companies in that they offer individual or group accident and health insurance.

There is a fundamental economic difference, however, between the nonprofit hospital service contract plan and the cash indemnity or hospitalization expense policies offered by stock and mutual insurance companies. In the plans approved by the American Hospital Association, participating hospitals underwrite the services; they guarantee to fulfill the contracts and they "hold the bag."

It is this definite assumption of responsibility by the participating hospitals which makes it necessary that the American Hospital Association supervise the public and administrative policies of these plans.

The emphasis on public welfare is exemplified by the family contract — a flat rate per month per family, regardless of the number or sex of the dependents. Typical contracts are those of the Pittsburgh or St. Paul plans which give "full" and "half" dependent coverage, respectively.

The Pittsburgh Hospital Service Association enrolls employed subscribers (either sex) at 75 cents a month, husband and wife for $1.40, and husband, wife and dependent children under 19 for $1.75. The Minnesota Hospital Service Association charges 75 cents per month per employed person yet covers an entire family with one or more dependents for an additional 25 cents per month, a total of $1. Dependents receive half coverage; that is, the association pays half their hospital bills.

It is obvious that rates such as these place a heavy "loading" upon the employed subscriber; for an employed person (male or female) requests less hospital care on the average than one not gainfully occupied. The family is the "unit of income" even if not the unit of hospitalization. Large families require more care than small ones, yet the breadwinner can afford less for hospitalization as the family increases. Consequently, any plan which ensures the payment of hospital bills must recognize "ability to pay" as well as "need" for service. The rates for families have been adequate to cover service to families, although the additional charge for the "wife" may not always cover cost for adult female dependents.

The Committee on Hospital Service has accumulated financial data for all "approved" plans. The total earned income for eighteen plans in operation more than twelve months on Dec. 31, 1937, (not including New York City) was $3,600,000. Of this total 60 per cent was paid to hospitals for service to subscribers, 21 per cent was used for acquisition and administration and 19 per cent has been retained for surplus for contingencies. New York City proportions for an equivalent total are about 5 per cent higher for payments to hospitals.

The proportions vary among the plans. During the last six months "loss ratios" have increased but administration and acquisition costs have decreased to a greater degree. These costs now range from 11 to 15 per cent in plans that have been in operation three years or longer.

### Responsibility to Subscribers

Special enabling acts for the establishment and operation of nonprofit hospital service associations now provide regulation by the departments of insurance and compel the hospitals to assume direct responsibility to the subscribers. This responsibility is definitely implied in the various enabling acts. In Maryland the provision is incorporated in the law as follows: ". . . each contract . . . obligates . . . each hospital party to render the service to which each subscriber may be entitled under the terms and conditions of the various contracts issued . . . to subscribers to the plan."

Hospitals should not guarantee cash indemnity for expenses at the time of sickness. It is different, however, for a group of publicly supported hospitals to guarantee services upon receipt of a total sum which remunerates them adequately for the care provided. Hospitals can estimate the total amount of care which a group of the population will require and can agree individually and jointly to make contracts to provide this care for a stated amount of money.

### Where Service Plans Differ

Some members of the legal profession and some hospital administrators have argued that because the hospitals make direct contracts to provide service these plans are not a form of insurance. This seems a specious argument. The only fundamental difference between these hospital service plans and the cash indemnity plan is that the risk falls upon the hospital rather than on the stockholder and the intention and ability of the hospital to provide service are substituted for cash benefits.

Hospital people know nothing about the details of insurance in their capacities as hospital executives or trustees. They do, however, understand hospital service and are able to make reasonable estimates of the cost of service to a group of people. It becomes a problem, then, to follow sound advice in estimating the probable amounts of service and best methods by which subscribers may be enrolled and certified for benefits. The executives of insurance companies, recognizing the nonprofit character and public welfare values of these plans, have been helpful and the executives of existing plans are learning more from day to day.

The nonprofit associations have not sold successfully individual hospital service insurance policies. They have learned from private companies the advantage of group insurance in

# Provides Service Not Cash

**The director of the committee on hospital service of the A. H. A. makes an official statement on the relations between hospital service plans (with 2,000,000 subscribers at the present time) and participating hospitals**

the matter of collections, the improvement of selection and the minimization of cancellation. Practically all of the plans at the present time insist upon enrollment through the place of employment, although many of them are now permitting small groups to enroll. The Minnesota plan will accept two persons with a common employer. More recently several of the plans have followed this trend to its logical conclusion and enrolled self-employed or retired persons.

Experience indicates that 100 per cent of enrollment among people with a common employer gave equally good selection from small groups and large ones. Experience with self-formed groups, representing employes from different places of business, has been unsatisfactory.

The question has arisen as to whether or not hospitals have assumed an unjustified risk, considering their present dependence upon public support. Logically the hospitals assume no new risk. They already are under legal and moral responsibility to serve all members of the general public. Hospital insurance plans enable many patients to pay bills who otherwise might depend upon charity. A hospital service plan should pay adequately for services received by subscribers. The total revenue to the participating hospitals may exceed that collected directly from the same patients.

Historically, the hospital service plans have paid the hospitals adequately. In some instances the payments have been less than the nominal fee schedules for services received but more than the costs of the services received by subscribers and considerably more than the additional costs of admitting the subscribers as compared with maintaining empty beds.

In cases of epidemics the hospitals incur no more risk than if the plan were not in existence, for epidemics are not limited to policyholders. The effects of epidemics have been greatly overemphasized in the public mind. Six cases of infantile paralysis in a town of 50,000 constitute an epidemic; 25 cases of scarlet fever or 50 cases of influenza preempt the newspaper headlines for several days, but they do not affect greatly the total number of admissions in any metropolitan area during a twelve months' period. Even the influenza epidemic of 1917 and 1918 did not account for more than 10 per cent of the total annual hospital admissions. It would be a large epidemic that would double hospital occupancy beyond its average for sixty days.

### Building Up Surpluses

I have recommended the accumulation of surpluses equivalent to as much as one-third of a year's hospitalization. A number of plans already have exceeded this average for their enrolled subscribers. In New York City at the present time more than 20 cents of every dollar is being credited to a surplus account for emergencies although the insurance department requires only 4 per cent of the earned premiums to be credited to such account.

Recently the board of directors of Associated Hospital Service of New York received approval from the department of insurance for the following allocations of earned income: 75 per cent for hospitalization; 10 per cent for contingency reserves, and 15 per cent for administration, including acquisition.

Any tendency for subscribers, doctors and hospitals to abuse the privileges of the hospital service association has not been as pronounced as it was feared. The patient has no direct economic incentive for excess hospitalization inasmuch as he must remain under the care of a private physician and all payments are made directly from the association to the hospital.

There appears to be no clash between the economic interests of hospitals and those of stock and mutual insurance companies. Accident and health insurance individual policies appear to be more easily sold in areas where nonprofit associations are successful. Prospects for accident and health policies thus receive greater income protection and cash benefits in the private policies.

The hospitals of the United States are currently underwritten by the general community. The nonprofit hospital service association is organized to help the sick man pay his hospital bill, not to help the hospital pay its bills. The public must support the hospitals regardless of revenue from private patients. Private insurance companies, therefore, must compete with an industry that already is subsidized by the general community through the provision of tax-free and donated capital as well as the guarantee of support through voluntary contributions and taxation.

The American Hospital Association does not take an antagonistic position toward soundly financed stock or mutual insurance companies. Any soundly financed insurance company has a right to offer cash benefit policies for the costs of sickness. If the private companies can offer more hospital service for less money than the nonprofit service association, the public will gain. The association

does, however, warn hospitals and the general public from any affiliation with fly-by-night promoters who are more interested in immediate gain for themselves than ultimate service to their policyholders.

A nonprofit hospital service plan requires the full cooperation of member hospitals. The economic and social interest of hospitals and the nonprofit hospital insurance plans are identical. The plans are in reality the agents of the member hospitals which provide the service, even if the legal status may be defined otherwise.

This fact places a responsibility upon the hospital to provide the best possible service under the terms of the contract and upon the management of the plans to give the participating hospitals complete financial and statistical information. Without the active and informed support of the member institutions no plan can develop the maximum confidence among the subscribers and the employers of a community. Hospitals are and should be cooperative rather than competitive institutions. Consequently, there should not be more than one nonprofit service association in the same community or serving the same section of the community.

Hospitals have never been a form of private enterprise similar to factories, department stores or insurance companies. Hospital care has been provided to the general public regardless of the individual's ability to pay at the time of need. If hospitals had been private enterprises, cash indemnity insurance for hospital bills would have developed under private insurance companies. Hospital care insurance, like hospital care itself, stands midway between private enterprise and social insurance.

A nonprofit association established for public welfare receives public support from the press and other agencies of communication which could not be purchased for large amounts of money. The hospitals continually maintain a reserve through their contractual arrangements to take care of subscribers, regardless of the ability of the association to pay stated amounts. The absence of competition and the lack of need for paid publicity and advertising would seem to make it possible for the hospitals themselves to provide their services more economically than even the best and most efficiently managed private company.

At the present time more than fifty well-known insurance companies have enrolled their employes in local nonprofit hospital service associations. Some of these companies have available in their own portfolios hospitalization expense contracts for individuals or for groups. Many of them are, of course, selling income protection benefits for people during periods of hospitalized illness.

Nonprofit hospital care insurance is something new. It differs from insurance offered by stock or mutual companies in that legal responsibility for benefits rests upon the hospitals instead of the stock holders or policyholders. Moreover, subscribers to hospital care insurance plans receive service, not cash. No other arrangement would justify public support or participation by publicly supported nonprofit institutions.

The enabling acts of the various states have rightly prevented nonprofit hospital service associations from contracting to pay cash benefits to subscribers and have limited them to the provision of "hospital service" or "hospitalization."

Administrative efficiency and legal responsibility are thus in accord.

The question as to what benefits may be provided under the category of hospital service or hospitalization has been answered by the customs of each community. In general, the services provided to subscribers through hospital care insurance contracts have been the same as those appearing on the hospital bills of other private patients of the institutions. A patient is primarily interested in receiving the hospital services necessary to adequate diagnosis and treatment. A stated amount of cash may or may not be sufficient to pay his hospital bill for these services.

# Initiating a Nurses' Library

HENRY GREENBERG, M.D.

IN THOSE hospitals that conduct schools of nursing the question of recreational facilities for the nursing body is always given appropriate consideration. When the service is made up entirely of graduates the institution often feels no responsibility toward its personnel. This detached attitude is interpreted as a lack of consideration and does not lead to the type of cooperation and interest that the hospital expects of its nursing staff.

While it is a fact that money is not always available for so-called nonessential purposes, there remain other means at the disposal of a hospital to afford opportunities for mental as well as physical relaxation and recreation.

At Morrisania City Hospital, New York, a municipally controlled institution where funds are restricted, a room was recently set aside in the nurses' home for the establishment of a library. It was possible to assign a regular employe to act as librarian during specific hours of the day. With a nucleus of a handful of nurses who contributed books and who, in addition, subscribed the sum of 25 cents monthly, the library has grown so that there are now available 178 volumes and the membership has grown to include 124 nurses.

Our present collection of book titles consists of fiction, nonfiction and a few selected scientific volumes which are purchased from the proceeds of the subscription. Members may borrow as many books as they desire but they are required to return them in two weeks so that each book will not remain out of circulation too long.

Those of us who were anxious to establish the library and who were active in its development are gratified at the response obtained in making our efforts a success. Evidences of improved spirit have already manifested themselves and it is certain that the hospital will benefit from this and similar projects.

# How Many Beds Are Enough?

ALDEN B. MILLS

"HOW many beds are enough?" asks a hospital consultant. It is a good question. Too many beds are a waste of the public's money. If there are too few beds, hospitals must ask patients to wait or "double up" with a resulting loss of comfort and increasing difficulty of service.

Decision regarding the necessary number of beds affects hospital economics in several ways. Money invested in providing bed capacity cannot be used for equipment or salaries. An increase in physical plant entails continuing readiness-to-serve charges as well as interest and depreciation. Hence it affects per capita costs.

On the other hand, inadequate facilities also may increase somewhat the cost of service through increased difficulties for the nursing, housekeeping and medical staffs. Overcrowding of patients and putting them into areas not suitable for their care undoubtedly affects their mental attitude and, perhaps, the speed of their recovery. If inadequate quarters and facilities add even one day to the average length of stay, this increased cost will swallow most or all of the "savings."

A voluntary hospital catering to private and semiprivate patients also must consider the standards of its clients. If the community is accustomed to obtaining comfortable, adequate accommodations and particularly if such accommodations are available in other institutions, a hospital that persistently crowds patients into cramped quarters or turns them away will jeopardize its patient following.

No hospital should enter upon an extensive building program without scientific study of the need for the additional facilities and the probable utilization that they will enjoy. On the other hand, when a hospital has made such a survey and has discovered that there is a real need for additional facilities to meet the demands of its service area, it should not be deterred by sweeping statements that "the hospitals of the United States are overbuilt." Overbuilding in one area will not satisfy the need for hospital service in others.

The basic attitude of a board of trustees toward this problem will be determined, in part at least, by its ideals of hospital service. It may believe that the hospital's duty always is to have suitable accommodations for any persons who may apply, regardless of sex, race, age, medical condition and economic group. At the opposite extreme it may feel that the hospital should have only sufficient provision for the average number of patients which it receives during the year and that it should take care of peak periods by using sunrooms, porches, corridors and other spaces not designed for patient occupancy or should turn away patients when accommodations are full. Opinion ranges anywhere between these two extremes.

Certain basic facts make it difficult or impossible for a hospital to render acceptable service to its community and at the same time to maintain an annual occupancy of 100 per cent. These factors include fluctuations in "demand" resulting from week-ends and holidays and from variations in the incidence of illness from week to week and from month to month. Fluctuations in the public's ability to pay for hospital service also affects hospital occupancy, particularly in the voluntary institutions.

The foregoing factors reflect variations in demand. There are also variations in the supply of service. Chief among these, of course, are the age, sex, clinical, racial and economic limitations on certain of the beds. An empty bed in the obstetrics ward, for example, is of no service to a male surgical patient, nor is an empty crib of value to a private patient who wants de luxe accommodations in the gynecologic department. Racial segregation further complicates the problem.

In addition, occasionally facilities are out of use because of actual or suspected contagion or the need for cleaning, painting or other maintenance operations.

To obtain some definite information on the influence of some of these factors, a schedule was sent to several members of the editorial board of The Modern Hospital. Through their generosity and painstaking work, we have collected data on the daily occupancy for a period of twelve consecutive months in the 14 institutions: St. Luke's Hospital, Denver; New Haven Hospital, New Haven, Conn.; Finley Hospital, Dubuque, Iowa; Orange Memorial Hospital, Orange, N. J.; Muhlenberg Hospital, Plainfield, N. J.; St. Luke's Hospital, New York City; Vassar Brothers Hospital, Poughkeepsie, N. Y.; The Christ Hospital, Cincinnati; University Hospitals, Cleveland; Jewish Hospital, Philadelphia; Baptist Memorial Hospital, Memphis, Tenn.; John Sealy Hospital, Galveston, Tex.; Hospital Division of the Medical College of Virginia, Richmond, and Vancouver General Hospital, Vancouver, B. C. In addition, through the courtesy of H. J. Southmayd of the Common-

**Relation Between Size and Fluctuation in Occupancy**

| Hospital | Bed Capacity | Difference Between Annual Average Occupancy and Average for Various Units Expressed as Per Cent of Annual Average: Highest Day of Year | | Highest Week of Year | | Highest Month of Year | |
|---|---|---|---|---|---|---|---|
| A | 1091 | 0.7 | | 7.4 | | 5.0 | |
| B | 816 | 1.8 | 1.2 | 9.5 | 8.4 | 4.6 | 4.8 |
| C | 511 | 1.6 | | 17.9 | | 12.0 | |
| D | 475 | 2.6 | | 17.5 | | 16.2 | |
| E | 432 | 1.3 | | 11.8 | | 10.1 | |
| F | 426 | 2.2 | 1.8 | 11.7 | 15.1 | 9.5 | 11.2 |
| G | 400 | 1.5 | | 18.2 | | 11.2 | |
| H | 400 | 1.8 | | 13.6 | | 7.1 | |
| I | 382 | 2.0 | | 16.0 | | 11.3 | |
| J | 357 | 1.3 | | 18.7 | | 11.9 | |
| K | 274 | 2.8 | 2.0 | 16.4 | 16.5 | 10.5 | 9.6 |
| L | 242 | 1.6 | | 11.9 | | 6.4 | |
| M | 225 | 2.3 | | 20.8 | | 7.7 | |
| N | 89 | 1.6 | | 31.4 | | 14.0 | |
| O | 46 | .... | 1.6 | .... | 31.4 | 36.6 | 23.6 |
| | | | | | | 20.1 | |
| Average of Percentages..... | | 1.8 | | 15.9 | | 12.1 | |
| Average of Percentages..... (excl. Hospital O) | | .. | | .... | | 9.8 | |

wealth Fund, figures covering two years by months were obtained for the Community Hospital of Farmville, Va. Unfortunately, daily data for this hospital were not available.

Weekly fluctuations, *i.e.* the drop over Saturday and Sunday, vary substantially in the reporting hospitals. The difference between the average occupancy for the highest day of the week and for the lowest day was as high as 5 per cent of the total bed capacity (or rather bed complement) in one institution and as low as 1.6 per cent of bed complement in another. For the 13 hospitals reporting on this subject the average fluctuation was 3.4 per cent.

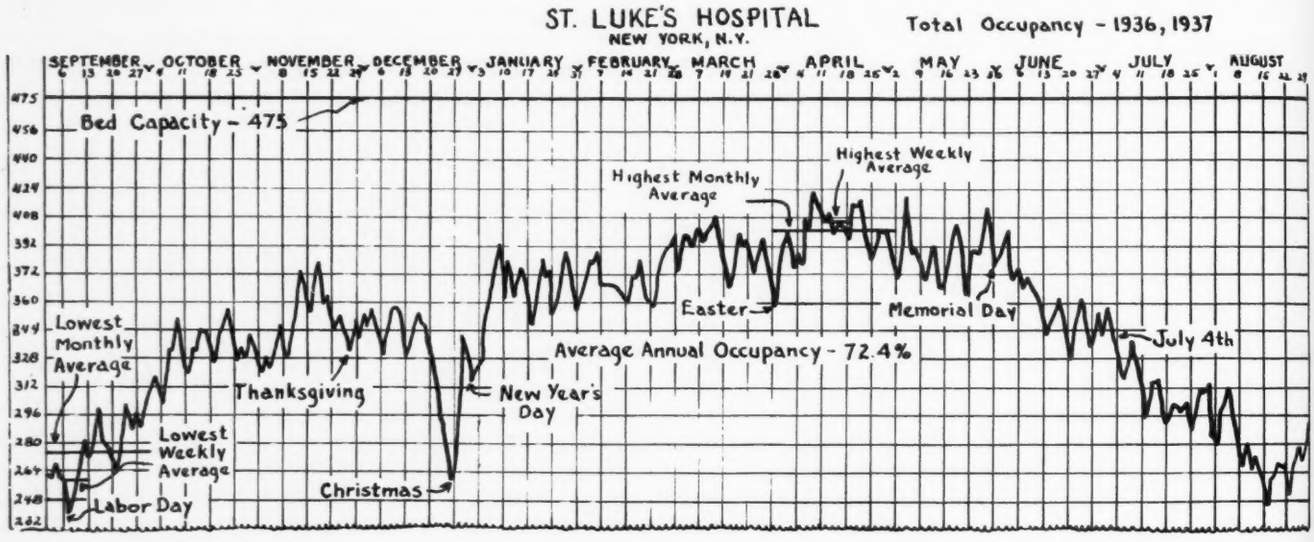
Sunday was the lowest day of the week in all except two hospitals. They reported Saturday as lowest. (The difference may have been fictitious as some hospitals take the census as of the close of the day and others as of its beginning.) Any day from Monday to Saturday may show the highest average occupancy, although Thursday was most frequently the high day reported.

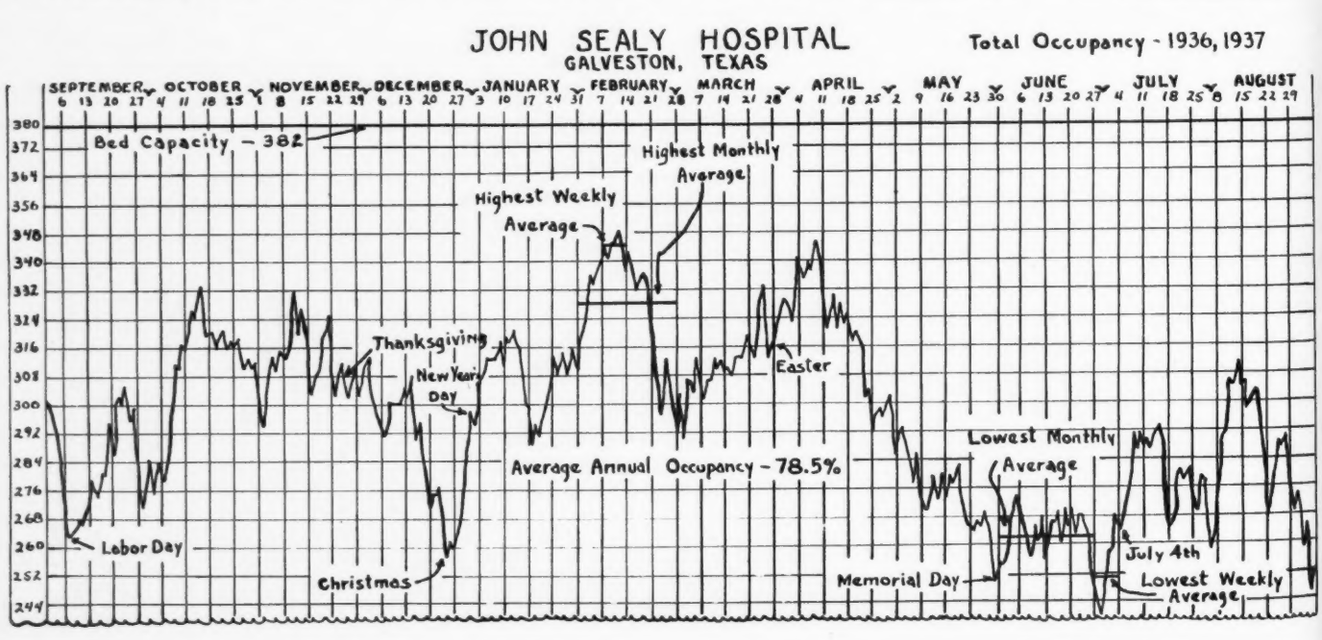
For present purposes the range of fluctuations within the week is not so important as knowledge of how far the high day of the week exceeds the annual average occupancy. Expressing this figure as a percentage of the annual average occupancy, we find that it ranges from 0.7 per cent to 2.8 per cent. The average for all 14 reporting hospitals (no data on this matter being available from the hospital at Farmville, Va.) was 1.8 per cent.

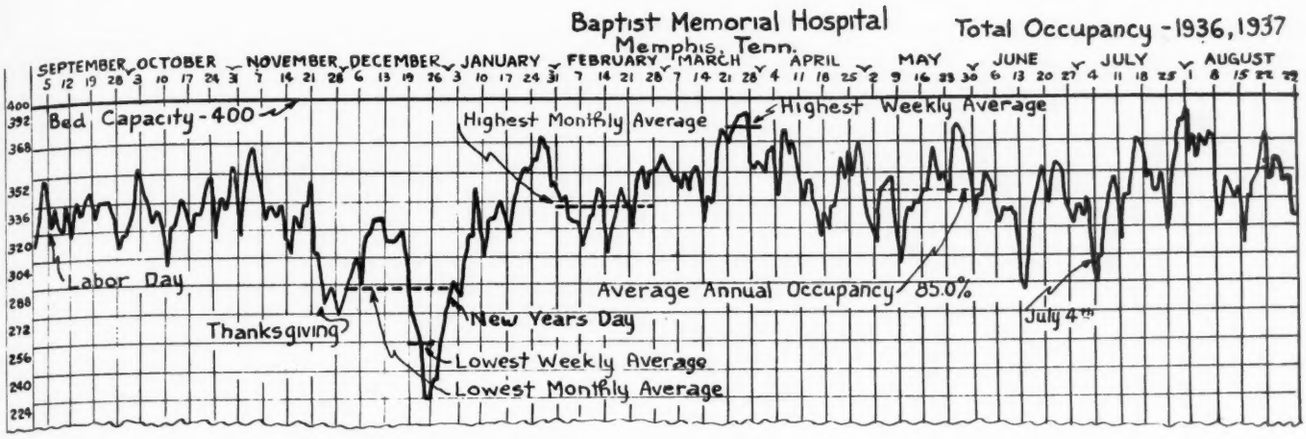
This means that when one knows the annual average occupancy of a hospital he must usually add about 2 per cent to take care of the normal weekly fluctuations resulting merely from the fact that the average is pulled down by the drop over the week-end.

The fluctuation within the week, however, is small as compared with the fluctuations from week to week. Three of 14 hospitals had a fluctuation from the lowest week to the highest of more than 30 per cent of bed complement and eight more had between 20 and 29 per cent. Only three reported fluctuations of less than 20 per cent and the average for all 14 reporting hospitals was 23.9 per cent.

When the figures are expressed as percentages of annual occupancy rather than bed complement, they are, of course, even higher: three






hospitals had more than 40 per cent fluctuation, six between 30 and 39 per cent and four between 20 and 29 per cent. The average expressed on this basis is 34.4 per cent.

But this weekly fluctuation is not divided precisely by the annual average. If it were, there would be 17.4 per cent above the annual average and 17.4 per cent below. Instead, the average upswing for all these hospitals carries the occupancy for the highest week to only 15.9 per cent above the annual average.

If a hospital decides to provide sufficient accommodations to care for the busiest week that it will be likely to have, it should therefore provide about 15.9 per cent more beds than its average annual occupancy to take care of this busiest week and approximately 2 per cent more to care for the fluctuations within the week. This, of course, is assuming that the experience of the particular hospital follows these average figures, which it probably will not do.

But the trustees and the contributing public may decide that the community is not willing to provide so well for its hospital patients. It may suggest that, for so short a time as one or two weeks, patients will have to be "doubled up" or put into emergency accommodations of one sort or another. That may be the sensible thing to do; it certainly is less costly.

If it is decided that the hospital will not attempt to provide facilities to meet the average occupancy for the highest week, perhaps the trustees will decide to meet the average for the highest month. On the average, the difference between the highest month and the lowest month equals 14.6 per cent of the bed complement of the 14 hospitals previously listed. If the figures for the Community Hospital at Farmville, Va., for two years are included, the average is 17.1.

Expressed as a percentage of the average annual occupancy this range from high month to low month constitutes 21.0 per cent for the 14 hospitals and 24.2 if Farmville is included.

Here again it is well to ascertain whether the annual average comes exactly in the center of the monthly fluctuation. For the 14 hospitals the difference between the highest month and the annual average was only 9.8 per cent, while for all 15 hospitals it was 12.1.

If the trustees decide, therefore, that they will provide sufficient facilities to meet the average demand during the highest month only, they will need to provide from 10 to 12 per cent more capacity than the annual average occupancy, plus the 2 per cent needed for fluctuations within the week. As may be seen by referring to the accompanying charts, there will be many individual days within the highest month when the occupancy will exceed the monthly average.

Thus we arrive at the conclusion that, on the basis of the hospitals studied, the bed capacity of an institution should be from 12 to 18 per cent higher than its average annual occupancy, if it is to take care of the normally expected daily, weekly and monthly fluctuations in demand for hospital service.

This fact may be expressed in another way. Taking into account only these periodic fluctuations that have been so far measured, a hospital may be considered to have reached its capacity when it is 85 to 89 per cent occupied for the entire year. Other factors to be discussed will bring these figures still lower.

The fluctuations indicated by these general averages may not, of course, represent the actual fluctuations for a particular hospital. The matter of size seems to play a part. For example, when the hospitals are arranged in descending order of size (as in the table on page 55) it appears that, in general, the hospitals of larger size have smaller fluctuations in occupancy than those of medium size while those of less than 100 beds have the widest fluctuations of all.

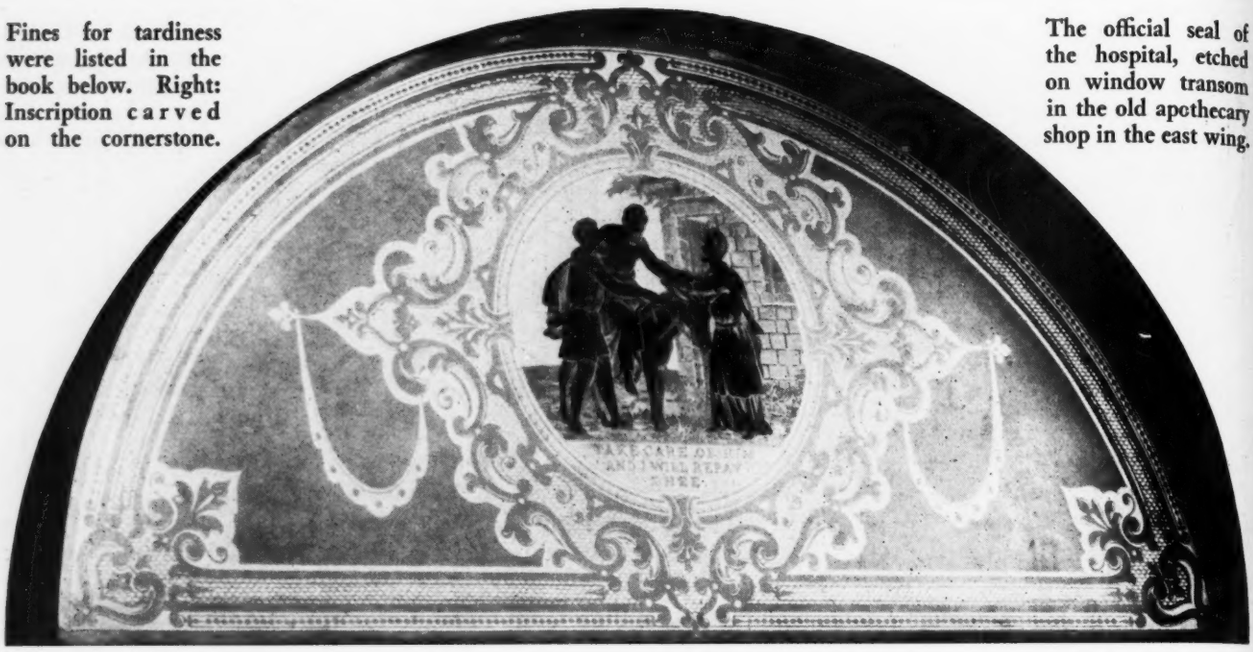
For the two hospitals of 750 beds and more, an excess of only 10 per cent more than the annual average occupancy would be sufficient to take care of the highest week and only 6 per cent above average occupancy would give enough beds to meet the average occupancy of the highest month.

Near the other extreme the hospital of 89 beds would require an excess of 33 per cent over annual average figures to enable it to meet the demands during the highest week and 15.6 per cent to meet the average of the highest month.

Figures on daily and weekly variations are not available for the smallest reporting hospital but in it the difference between the annual average and the highest monthly average was 36.6 per cent in 1936 and 20.1 per cent in 1937 or 28.3 per cent for both years combined.

The analysis of occupancy figures for the hospital as a whole for one year only is but a part of the story. A subsequent article (to appear in October) will analyze other factors.

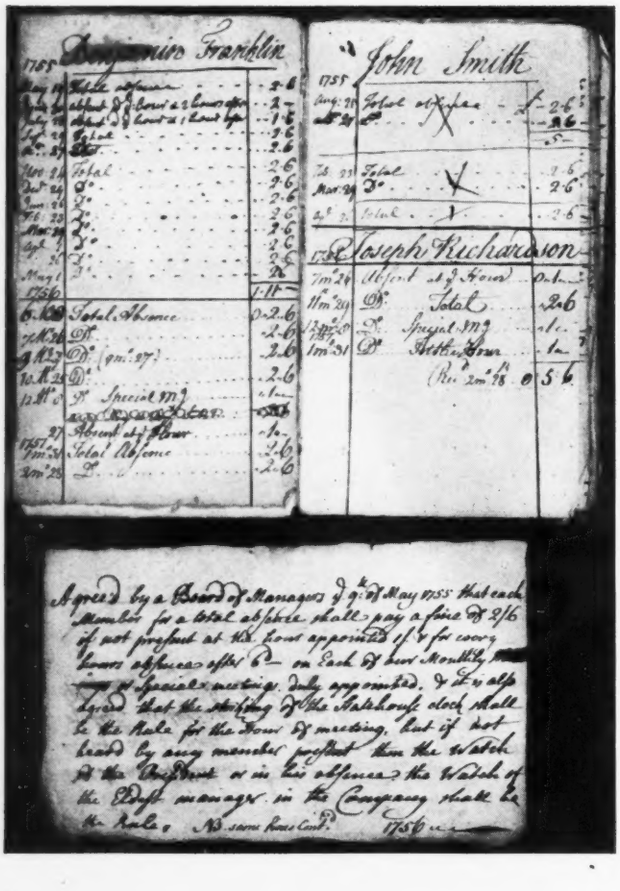
Fines for tardiness were listed in the book below. Right: Inscription carved on the cornerstone.



The official seal of the hospital, etched on window transom in the old apothecary shop in the east wing.

# It Happened in 1755

JOHN N. HATFIELD




THE year is 1755. It is early afternoon, presumably, of May 28. A holiday has been declared; the public schools have been dismissed so that the children can participate in the celebration. A large crowd, having first assembled on High Street (now Market) in Philadelphia, has marched

IN THE YEAR OF CHRIST
MDCCLV
GEORGE THE SECOND HAPPILY REIGNING
(FOR HE SOUGHT THE HAPPINESS
OF HIS PEOPLE)
PHILADELPHIA FLOURISHING
(FOR ITS INHABITANTS WERE
PUBLICK SPIRITED)
THIS BUILDING
BY THE BOUNTY OF THE GOVERNMENT
AND OF MANY PRIVATE PERSONS
WAS PIOUSLY FOUNDED
FOR THE RELIEF OF THE SICK AND MISERABLE
MAY THE GOD OF MERCIES
BLESS THE UNDERTAKING

**Pennsylvania Hospital as it appeared in the year 1814 to a former patient, J. G. Exilius, an engraver.**

to a building under construction "near the village."

The occasion is of historical significance because the cornerstone of the first permanent building of the first hospital in the colony is about to be laid. Joshua Crosby, president, and other members of the board of managers, together with the staff physicians and many contributors, lead the procession. Trudging along the dusty road from town to the new hospital building site with the other celebrants is 73 year old John Key, the first colonist born after the arrival of William Penn. He had been invited to assist in the ceremonies.

The dense forest partly surrounding the clearing resounds to the cheers of the multitude as the large piece of white marble, constituting the cornerstone, is deposited with due formality and with Masonic rites in the southeast corner of the foundation. On its face, carved by a local craftsman, is the inscription copied from the pen of Benjamin Franklin, which appears on the opposite page.

This scene with its Colonial atmosphere, tempered by the seriousness of the occasion and blessed by the presence of a goodly number of hardy, pious Friends, I visualize as I stand before one of the museum cases in the library of the Pennsylvania Hospital reading from a yellowed scrap of paper. The handwriting is that of Benjamin Franklin and the wording is that which was carved on the cornerstone. There are some arithmetical figures in the margins and elsewhere on the face of the paper, probably concerned with the cost of the stone and the inscription.

The stone has weathered the years and so has the building in which it was laid that May afternoon 183 years ago, four years after the institution was founded with the help and largely through the efforts of Benjamin Franklin who, during his lifetime took great interest in its welfare and served it in various official capacities.

As I stand before the case trying to orient my mind to the conditions and situations which prevailed when this country was in its infancy, my eyes are attracted to another document. Reading it, my thoughts take me through the years to another May day, that same year of 1755.

The board of managers is in session. It is almost time for the meeting and some of the members are missing. The president stands at one end of the table, his fingers toying with the heavy watch chain dangling from his pocket. Something must be done to discourage the tardy and penalize the absent. This business of managing a hospital is serious; it is a public trust. The hour has struck and the meeting is called to order. The president makes known his displeasure and earnestly suggests remedial action in the form of a rule as follows:

"Agree'd by a Board of Managers ye 9th of May 1755, that each Member for a total absence shall pay a fine of 2/6, if not present at the hour appointed 1/, & for every hour's absence after 6d on Each of our Monthly or Special meetings duly appointed. & it is also agreed that the striking of the Statehouse clock shall be the Rule for the Hour of meeting, but if not heard by any member present then the Watch of the President or in his absence the watch of the Eldest manager in the Company shall be the rule."

The resolution passed. (Incidentally fines for absence are collected today, it being the duty of the last elected member of the board to make an accounting annually.)

Leaving the meeting at this point, my thoughts return to the "Account Book of the Collector of Fines," the open pages of which only a moment before I was reading, and recorded on which are the names of managers fined, the dates and the amounts collected. This now old and worn book stood for a principle nearly two hundred years ago; its presence there in the case serves as a reminder that it would not be on display as a historic relic in one of the original buildings of the hospital today had it not been

for the broad, sound institutional foundation started, built upon and maintained by a succession of managers imbued with the spirit that influenced those enlightened, pioneering and sturdy managers of Colonial days.

Benjamin Franklin was probably the most versatile and certainly one of the most human men this country has known. That he was one of the founders of and an influential force in the Pennsylvania Hospital, along with his many other interests, is not surprising and is a matter of record. The display cases into which I have been looking contain many evidences in the form of documents, manuscripts and relics produced by his hands. They impress one with the simple greatness of the man; the personality of a kindly genius, whose handiwork and influence are felt by those of us who now are privileged to serve the hospital.

Among these Franklin items, to comment on a few, are, besides the cornerstone manuscript already alluded to, the first minute book of the board of managers, a book titled "Some Account of the Pennsylvania Hospital," the worn out first seal of the hospital and a note concerning the admission of a patient.

**On the library shelves are scores of rare books on natural history and herbs. In the cases are records, manuscript and anatomic drawings.**

Franklin was the first secretary of the board of managers and the second president. As secretary, he printed the charter of the hospital on his own hand press and bound the sheets as a preamble, in the initial minute book. The minutes of the first several meetings are in his handwriting. Close by is a copy of his "Some Account of the Pennsylvania Hospital; from its First Rise to the Beginning of the Fifth Month, called May, 1754."

It was written in narrative form and 1500 copies were printed by him in 1754. Near at hand is a cracked and much worn silver block on which is engraved the seal of the hospital. It is the original seal, engraved in Boston and broken across in 1833, having been worn out. Franklin was largely responsible for the design; the seal is circular and 2 inches in diameter. It depicts the Good Samaritan taking charge of the sick man and delivering him to the inn keeper with the inscription beneath "Take care of him, and I will repay thee." Typifying the humanness of Franklin and the spirit of the Pennsylvania Hospital as we are wont to preserve it is a manuscript, a small piece of paper preserved in one of the museum cases. It is in the form of a note addressed to the Matron, Elizabeth Gardner, and reads:

"June 4, 1753.

"Sister Elizabeth,

"Please to receive the Bearer into the hospital, & entertain him there till the Physicians have considered his Case.

Your Friend & Servt.,

B. Franklin"

Leaving the display cases for a moment, my eyes center on a chair, a very old chair of British oak showing evidence of having been put to much use. It was presented to the hospital in 1810, having belonged at one time to William Penn whose family contributed some of the land on which the hospital stands.

Reading from the letter of presentation from Henry S. Drinker to the hospital managers, I can visualize that beautiful old high back chair standing in the hall in the proprietary mansion house at Pennsbury on an "area elevated a few steps above the floor for the convenience of giving audience to the Indians." Sitting in it is William Penn surrounded by his personal attendants and grouped before him in the great hall many

Indians who seek audience with their trusted Quaker friend.

Crossing the library, through a window I see a larger than life size lead statue of William Penn perched on a marble pedestal in the center of the lawn, immediately to the south of the old buildings and facing Pine Street. Dressed in knee breeches, long top coat and flat crowned, brimmed hat of the period in which he lived, Penn is standing with most of his weight on the left foot. With his right hand he points to a scroll in his left hand on which is inscribed the following: "Charter of Privileges to Pennsylvania, MDCC. Almighty God being the only Lord of Conscience, I do grant and Declare that no Person who shall acknowledge One Almighty God and profess himself Obliged to Live Quietly under the Civil Government, shall be in any case molested or" . . . (Here the scroll folds up).

It is interesting to note that Franklin, while on a visit to London in 1775, had visited Lord Le Despencer where he had seen the statue. Being impressed by it he expressed a wish for a duplicate to be placed in the state house grounds in Philadelphia. Lord Le Despencer's successor was no admirer of Penn and sold the statue for old metal. It subsequently found its way to a junk shop, where John Penn saw it and bought it for presentation to the hospital, the statue arriving on the ship "Pigou," Sept. 24, 1804.

I pause to reflect and to drink in the vitalizing atmosphere of that old library room, lined from floor to ceiling with thousands of books, some of them nearly 450 years old, (the first one having been presented to the hospital by Dr. John Fothergill of London in 1762). I gaze as I have a hundred times, at the wooden balcony circling the entire room, its railing supporting paintings and engravings of objects and personages identified with the hospital during nearly two hundred years. There in one corner, behind glass doors, the same as those that protect the books, is a cleverly contrived winding wooden stairway leading upward to the balcony and downward to a large burglar-proof vault.

In a wooden case near one end of the room are stored 17 colored anatomical charts about two feet wide by three feet high executed in crayon by the Dutch artist VanRymsdyk in 1755. The charts came into the possession of Doctor Fothergill who presented them to the hospital at which they arrived in 1762. They originally were used by Dr. William Shippen Jr., in teaching medical students in the wards.

Near by is a spring dial clock built and presented to the hospital by Thomas Wagstaffe in 1762. Just outside the doorway stands a mahogany cased grandfather clock fashioned and mechanized by David Rittenhouse about 1780.

Hanging in the hallway, one on each side of the doorway of the library, are two life size oil portraits by Thomas Sully. The portraits are of Dr. Benjamin Rush, signer of the Declaration of Independence and the most eminent American physician and author of his day, who served on the medical staff of the hospital from 1783 until he died in 1813, and Samuel Coates, a widely known Philadelphia merchant, who was a member of the board of managers from 1785 to 1825—a period of 40 years and four months.

The spaciousness and tranquility of the library room, with its historical atmosphere, are a dreamer's paradise. There, the scholar, the student, the antiquarian, the writer, the painter or just any average appreciative person can find inspiration.

I always leave the library and its precious store of relics reluctantly. Each time I leave it with a feeling that I have gained something by having been there. To me the place is inspiring for it is a veritable museum of hospital history of this country. It reflects the hardships, perseverance and indomitable spirit that laid the foundation of the great hospital system of America.

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# We Planned It That Way

R. M. CUNNINGHAM JR.

EVERY institution has received an occasional gift or bequest that came as a complete surprise. It might be thought that the giver, for mysterious reasons of his own, wished to be rid of a sum of money and that the institution stumbled luckily into his path when he was in the mood.

But we know it doesn't happen that way. Without exception, such occasions are found to be the result of some experience or knowledge which has convinced the giver of the institution's worth. Nor is such a conviction alone enough to prompt an actual gift. It is merely the fuel to which must be added in most cases the spark of an emotional or sentimental association.

Obviously, it is not often that the conviction of worth and the vitalizing emotion will occur fortuitously to produce action. Surprise gifts are few.

The gifts that we obtain by our own efforts arise from precisely the same combination of circumstances. Certainly it is no reflection on the giver that his conviction of our worth came from information that we supplied or that the emotional or sentimental spark which stirred him to action may have been of our own devising.

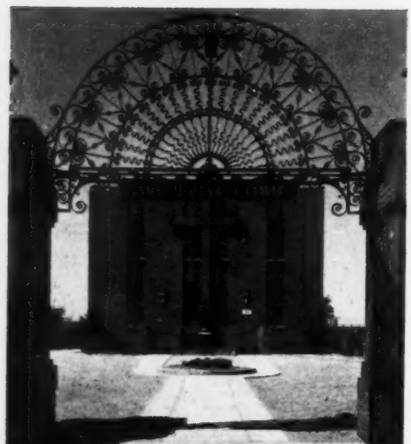
We may know in a general way that persons are in a position to make gifts but our knowledge is by no means exact, and we have no way at all of knowing just when any one of our "eligibles" may be preparing to draw up his will. Thus, there is no possible way for us to pitch the voice of our good works to produce the desired conviction of worth in the right place at the right time. The only sensible procedure is to make certain that the voice speaks constantly and that the entire community hears.

Our voice is sure to be heard and to arouse some responding interest. We must judge from each response how best to proceed to kindle the fuel into flame. It won't be often that our efforts will meet with the instant success of an immediate gift.

When we have planned it this way, however, no gift ever can be completely a surprise. No gift should be.

# Out-Patient Clinic in Denver

VERY REV. MSGR. JOHN R. MULROY



AVE MARIA CLINIC in downtown Denver, the joint out-patient department of the three large Catholic hospitals of the city, is the solution for several welfare and health needs of the community. Two sets of needs existed that have been met in part by the erection of the clinic building and through its work.

The first need was an adequate clinic or out-patient department downtown where the ambulatory sick poor could go for diagnosis of ills, for treatment of small ailments, for temporary relief for serious ones and for arrangements for actual hospitalization without cost, if that became necessary.

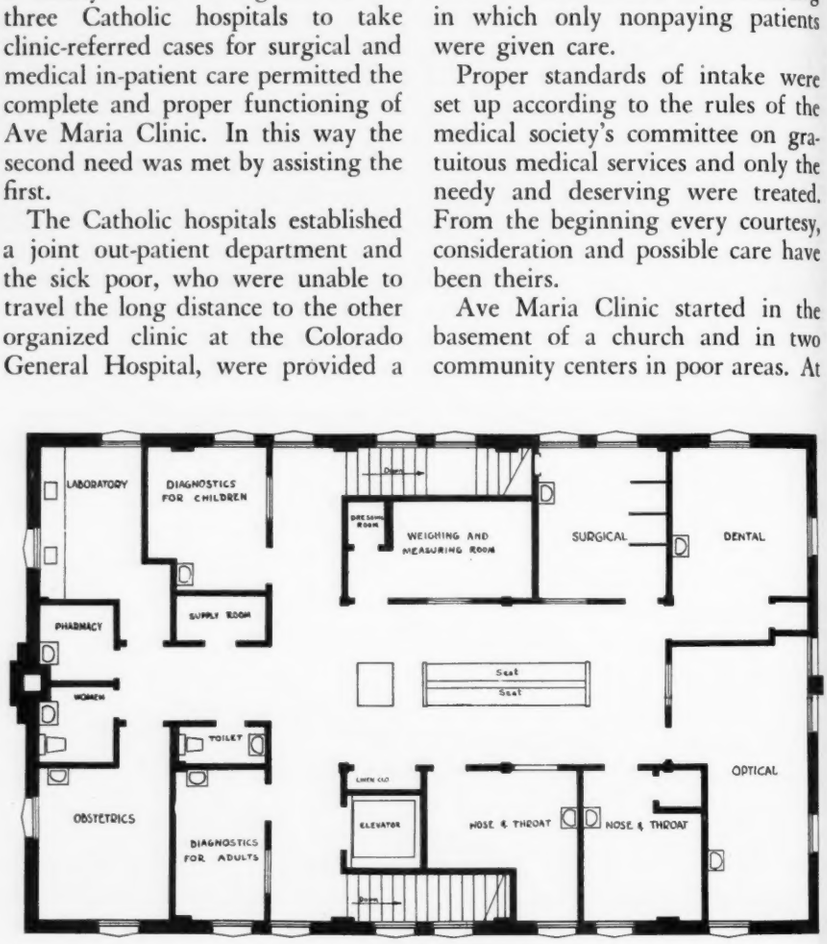
The response of a large group of doctors and dentists made the diagnostic and regular clinic treatments a reality. The willingness of the three Catholic hospitals to take clinic-referred cases for surgical and medical in-patient care permitted the complete and proper functioning of Ave Maria Clinic. In this way the second need was met by assisting the first.

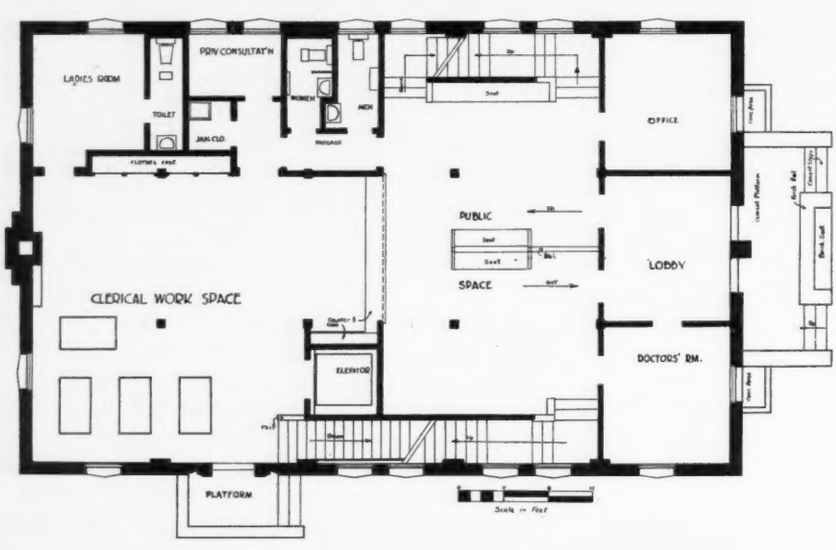
The Catholic hospitals established a joint out-patient department and the sick poor, who were unable to travel the long distance to the other organized clinic at the Colorado General Hospital, were provided a much needed doctors' office building in which only nonpaying patients were given care.

Proper standards of intake were set up according to the rules of the medical society's committee on gratuitous medical services and only the needy and deserving were treated. From the beginning every courtesy, consideration and possible care have been theirs.

Ave Maria Clinic started in the basement of a church and in two community centers in poor areas. At St. Anthony's Neighborhood House, at the Little Flower Center and at St. Cajetan's Church, the battle for the health of the sick poor began under Catholic auspices. Services were given by nurses, doctors, lay attendants and welfare workers. Enlightened, kind people of means were moved to make the task less difficult, the effort more effective.

Once convinced of the need, John Dower and his associates of the Mullen family and the Colorado Milling and Elevator Company immediately




**Left: First floor plan of the Ave Maria Clinic. Above: The second floor plan. Top: Clinic entrance.**

built and fully equipped the splendid plant.

Wisely, the bishop of the Denver diocese, Most Reverend Urban J. Vehr, incorporated the clinics as a nonprofit or charitable corporation. He is the corporation president. Doctors Spangelberger, Shea and Prinzing, representing St. Anthony's, Mercy and St. Joseph's Hospitals, serve on the board. Dr. J. J. O'Neill represents the dentists of the city. The director of Catholic charities is the fifth member of the board and is the executive secretary of the clinics.

The Community Chest accepted the institution as a member agency so that its operating costs were provided for at the start.

The arrangement of the clinic, while simple, has proved in operation to be well adapted to its purposes. The basement contains a large assembly room, which also is used for serving luncheons daily to undernourished school children of the district. There is a large storeroom, 12 by 20 feet; another, 10 by 12 feet, and a third, 10 by 6 feet. Another room adjoining the assembly hall originally was intended as a storeroom but has been converted into a kitchen. Approximately 275 school children are fed here every school day; the W.P.A. provides the salaries of the workers and the Federal Surplus Commodities Corporation, the food. The boiler and coal room and caretaker's room occupy the remainder of the basement.

Patients entering the front door of the clinic come first into the lobby and then into the public waiting space. Flanking the lobby are the office of the executive secretary and the doctors' room. Most of the first floor is used for clerical work space, public toilets and a private consultation room.

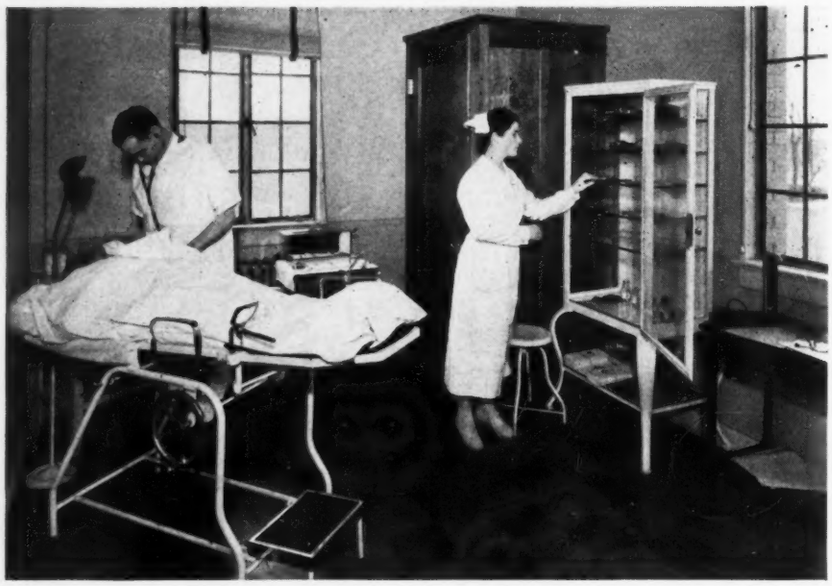
Most of the treatment rooms are on the second floor. Patients coming to this floor, either by the stairways or by elevator, are controlled by a nurse or clerk at the desk in the waiting room. The arrangement of treatment rooms around this central waiting room has been modified from the original plans but as it is now arranged it is satisfactory.

This little clinic cost about $60,000 to build and is largely fireproof. Our staff consists of 40 doctors (10 of

**Costs of Operation, 1936 and 1937**

| | *1936* | *1937* |
|---|---|---|
| Medical | $ 707.53 | $ 785.74 |
| Supplies and replacements | 55.39 | 119.98 |
| Grounds | ------- | 89.33 |
| Heat, light, gas, power and water | 540.45 | 809.27 |
| Laundry (at cost) | 29.09 | 46.85 |
| Insurance | 285.19 | 52.01 |
| Repairs and painting | 11.70 | 54.80 |
| Office expense | 88.14 | 157.24 |
| Telephones | 140.04 | 308.68 |
| Postage | 12.00 | 37.00 |
| Auto expense (individual owners) | 22.50 | 82.50 |
| Bank charges | 10.62 | 17.27 |
| Ambulance | ------- | 28.00 |
| Salaries—professional, office help and janitor | 3,281.40 | 4,929.75 |
| TOTALS | $5,184.05 | $7,518.42 |
| Cost per visit for two years | | $0.61 |

**Constructed of brick and largely fireproof, the Ave Maria Clinic building cost about $60,000. The basement contains an assembly room and kitchen. Below is a view of the patients' waiting room, always well filled.**



**One of the second floor treatment rooms which opens off a central waiting room and is conveniently near to the elevators and the stairway.**

whom serve in rotation each quarter), 16 dentists who likewise rotate periodically, one full-time nurse superintendent, one part-time assistant nurse superintendent, two volunteers from each of the three Catholic hospitals (two graduates and four students), three social workers (one of whom speaks Spanish), one clerk on the second floor and also a janitor.

The clinic has been in continuous operation since its opening in September 1935. Statistics of the services for the two-year period ending Sept. 1, 1937, speak to the credit of the doctors and dentists, the nurses and supporting agencies who have given their skill, time and money.

**Sixteen dentists, who rotate periodically, comprise the staff of the dental department.**

Here are some of the outstanding items on the two-year record:

| | |
|---|---|
| Total patient visits | 20,564 |
| Total cases | 5,748 |
| Total free hospitalizations | 1,146 |
| Three Catholic hospitals | 1,127 |
| Denver General Hospital | 16 |
| Children's Hospital | 3 |
| Prescriptions free by clinic | 3,729 |
| Paid by board of public welfare | 791 |
| Paid by patients | 1,432 |
| Eye examinations | 1,887 |
| Glasses provided | 343 |
| Dental clinic visits | 2,817 |
| Obstetrics, prenatal visits | 2,250 |

Many agencies and individuals cooperated to make this program a reality. The part played by the hospitals and medical and dental professions is evident. Nurses, both graduate and student, assist on the clinic days, Monday, Wednesday and Friday of each week. One hospital sends two graduates from the staff; two send two senior trainees each, one every clinic day. They are given credit for their out-patient service, which is under supervision of the clinic superintendent, an experienced and well-qualified graduate nurse, Gertrude Graef, who was given special training for the task at Firmin Desloge out-patient clinic, St. Louis University. Fifty medical men and sixteen dentists cooperate. The Visiting Nurses' Association and University of Colorado medical authorities assist in home delivery cases.

As there is no creed, color or race limitation, the bureau of public welfare honors prescriptions on these cases. The school authorities give glasses for public school children and the St. Vincent de Paul Society provides them for Catholic children.

Funds for clinic staff and ordinary overhead are provided largely by the Community Chest, supplemented by funds from local Catholic charities, St. Vincent de Paul Society, a Denver foundation and private donors. A medical aid association of Catholic ladies provides linens and makes dressings and layettes. The Federation of Catholic Nurses assists by donations from time to time.

All in all both in quantity and quality the work of Ave Maria Clinic illustrates the possibilities of an extension of free out-patient and in-patient health services under private auspices.

# The Board Asks "Why?"

JOSEPH C. DOANE, M.D.

IN MANY hospitals the annual meeting of the board of trustees is likely to be concerned chiefly with a study of the administrator's operating sheets for the fiscal year. At this time the board faces what it has dreaded for many months, that a moderate, or even an alarming deficit must be met.

Under no other circumstance is a diagnosis as to the true caliber of the board so easily made. When incomes are ample and no internal difficulties exist, any board of trustees may appear serene and urbane. When financial difficulties arise, a truly conscientious board manifests itself.

### Superintendent as Scapegoat

Boards of trustees react in various ways to such a situation. One type endeavors to place the blame on somebody and often the administrator is made the scapegoat. If he is wise and seasoned, he will have protected himself over and over again during the previous twelve months. He will have prepared monthly operating statements in which the financial trend of the hospital is clearly pictured. He will have pointed out declining revenues. He will have offered suggestions as to the remedy long before an embarrassing deficit occurs. If he senses that the board feels entirely too secure, he will have dispatched from time to time special memorandums about the growing disproportion between the hospital's income and receipts.

There are executives who hope from day to day for improvement that never comes, who procrastinate because the day of reckoning — the annual meeting of the board — is still a long way in the future.

If an executive permits his superior officers to remain in ignorance, then he deserves whatever punishment is meted out to him. He has taken upon himself the responsibility of balancing his budget. He has disregarded one of the most important rules of administration in not permitting those to take responsibility whose duty it is to do so.

If the board of trustees, after having been informed, does not act on the recommendation of the superintendent, then it alone must take the blame. A board of trustees, no matter how unfair it may be, cannot consistently blame the administrator for a deficit if he has kept the board consistently informed.

A second reaction to a deficit is a board's insistence that immediate action be taken. This response often assumes the nature of a panic and results in steps being taken without thought of the consequences or even without careful evaluation of their necessity. Such boards may radically eliminate departments, unfairly pare down personnel rolls or assume that there is only one side to hospital operation and that has to do with the amount of money expended. This is not businesslike. No individual or institution should adopt a drastic policy of retrenchment without viewing all angles of the problem.

### Board-Met Deficits Poor Policy

A third reaction, which is satisfactory from some standpoints but hardly one to be universally approved, is for a board composed of wealthy members to meet the deficit themselves on a per capita basis. This method of financing the hospital is untrustworthy insofar as the future is concerned. Wealth is often fugitive and the manifestation of a spirit of generosity in families is likely to vary with the rise and fall of their economic fortunes. To expect a board of trustees to balance the budget each year by making personal contributions is hardly a sound method of financing.

Again a board may decide that it is proper and advisable to bring in a so-called expert. This reaction has good possibilities since one who is not too close to the operation of the hospital may detect leaks or inefficiencies that have been overlooked. Nevertheless, often accurate information on many points relative to operation can be obtained from the administrator. A board should not overlook the value of a prophet even in his own country.

Finally, the executive may be asked for a report explaining the occurrence of an unusual deficit and to recommend how it may be met and how the hospital may be operated during the coming year in a financially satisfactory manner.

### Uncovering the Causes

The truth is never reached by evading realities. Months before the annual meeting the superintendent should have recommended ways by which incomes could be increased or expenses reduced. But if this has not been done, the matter resolves itself into making a financial diagnosis and the application of economic treatment. The superintendent should go about this task by assembling materials that he has been preparing during the previous year or years that will assist him in making his report. There is frantic scurrying about in the bookkeeper's office and burning of midnight oil if salient facts and figures are unavailable and previous comparative statements of departmental operations are not at hand. The executive with administrative foresight will have had under way for many months or years an operating graph showing per capita costs with a differential curve showing loss or gain on each type of patient day. He will have prepared and will have been closely watching a cumulative graph with breakdown showing the hospital's experience in ward costs and incomes covering the full pay, part-pay and free cases, as well as comparative figures relative to private and semiprivate days of occupancy. Deficits do not grow like mushrooms overnight.

When these data have been prepared, the administrator continues

with his diagnostic efforts. He has as a yardstick his experience of other years and the experience of similar hospitals. He has come to know with relative certainty, for example, that in his hospital May and June are likely to be large operating months, that July and August will show the lowest hospital occupancy and will have perhaps the greatest disproportion between per capita costs and per capita receipts. He is thus able to predict his gross income for the remaining months of the year and to forecast gross expense.

He is able to dissect income figures and to prepare comparative statements by month or by quarter. From a study of gross income expense and service figures he may prepare such informative statements as the comparative percentage of gross expense that is represented by earned income, the percentage received from endowments and from the community chest and the percentage of gross expense representing the deficit. Often earned income may increase while endowments dwindle and community chest receipts decline.

Certainly it cannot be the fault of the hospital executive if a community drive fails or if invested monies do not earn the usual income. The hospital administrator certainly cannot be blamed for matters not under his control.

### Helpful Information Unearthed

In the inspection of the institutional deficit certain causative factors may stand out. A rate card adjustment may not have fulfilled its promise, or the staff members may not have met their obligations as salesmen. Perhaps the administrator may point out that the board has elected physicians with too many staff appointments or those who are not loyal to the institution.

All this information is useful but should never be employed by the executive as an alibi to save himself. In such a study the executive may learn that the community does not favor expensive rooms and needs more in the lower brackets. He may learn for the first time that poor credit investigation is being made and that a large proportion of the year's income remains uncollected. Perhaps he may conclude that the year's deficit consists of an unexpected decrease in community chest appropriations, plus an unusual expenditure for equipment or salary increases.

It is the executive's duty to point out that the successful conduct of a hospital depends upon bringing gross income and expense figures closer together. If per capita costs have not risen out of proportion to general conditions the problem is not one of retrenchment alone.

Boards and administrators may be divided into two general classes. Those who look upon expense items alone as threats and those who believe that to increase revenues — to conduct a good hospital — generous spending is necessary. The former believe that financial salvation is to be found only in ruthless cutting. The latter curtail wisely, maintain standards and yet believe in the practical exemplification of that eternal verity that he who gives most gets most.

### Good Hospital Never Foreclosed

A good first class hospital is not foreclosed when it cannot pay its bills. The public is looking for such institutions. The business man who prides himself on being "hard boiled" often serves as a balance wheel to the board of trustees but his kind certainly should not be in the majority.

These are some of the thoughts that must pass through a conscientious superintendent's mind as he goes forward with his study. Why, he asks himself, is his deficit greater this year than last? If there were greater expenditures what return was obtained? He is reminded that the board authorized all expenditures and that he used no tricks and no subterfuges to obtain a new gas machine, a change in the power plant or new furnishings in the private suite.

He inspects the major items in his gross expenditures. He observes that he has spent 20 per cent of his per capita cost for food and less than 45 per cent for personnel, which are within safe limits. By measuring with the yardsticks that are at hand, he finds that he has not exceeded the customary percentages in usual items. He notes on the pie-graph of other years that there have been no drastic departures. He decides that his per capita cost is as low as good service will warrant and that the difficulty lies in a falling income.

The administrator is now ready to marshal facts for presentation. A blackboard or large sections of cardboard are useful in dramatizing the facts to be presented. A copy of this report for each board member may suffice.

The groundwork having been well laid, he now prepares his recommendations for the meeting of the finance committee. He recommends that members of the staff who have not been sending patients to the hospital be interviewed. He suggests a readjustment of several items in the rate card. He discusses the advisability of publicizing various departmental activities of the hospital. He suggests greater activity on the part of the endowment committee of the board. He shows that community chest and government incomes are totally inadequate to meet the expense of the free service rendered by the hospital.

He advises against eliminating any department except as a last resort. He stresses the expectations of the public for a rounded service, including all of the specialty activities conducted by the hospital. He presents comparative tables of salaries paid elsewhere in answer to the suggestion that wages be lowered. He advises against excessive economy in the dietary department, stressing the fact that good food is one of the hospital's best advertisements. He shows the futility of reducing ward admissions without closing wards because of a necessary persisting overhead. He advises against hurried budget slashing and suggests that the first quarter be used as a trial period before drastic steps are taken.

### May Call in Consultant

If all else fails, he advises calling a consultant and he notes mentally the advisability of employing one who is not looking for a job.

To the average intelligent board, that is willing to accept responsibility, such a report, containing constructive recommendations, backed amply by experience figures, usually will strike a responsive note.

# Integrating Nursing Education

ELSIE E. KRUG, R.N.

LEARNING must be built around functional experiences. Each part of the nursing program should be linked with the next part so that the student is aware of her progress and increasing responsibilities. Thus she may be able to synthesize knowledge and technics into unified experiences which become more and more complete when she is given the opportunity to apply them in actual situations.

Integration of learning would to a great extent be defeated if, upon arrival at the maternity division, the student were assigned at once to the delivery room to scrub for the morning deliveries before she had an opportunity to become oriented to some of the simpler responsibilities. On the other hand if, during the latter part of a program in a subject such as obstetrics, the students prepare and pool their knowledge in the discussion of some project, each student has an opportunity to draw upon such knowledge and skills as she has learned in her classwork as well as from items of experience on the ward.

### Subjects Taught in Units

The degree of integration, then, will depend on the manner in which a course is taught as well as the way it is planned. This does not mean that everything must be taught in one course, but rather that all courses should be taught so that the integration occurs in the student's own mind. The Curriculum Guide bears out this idea by suggesting that the subject material be taught in units in which the various items of knowledge and skill may function.

In setting up a program for the three year students in the Jewish Hospital School of Nursing, St. Louis, the course includes a preliminary term of four months, during which the students receive 105 hours of anatomy and physiology, 80 hours of chemistry, 60 hours of microbiology, 30 hours of psychology, 30 hours of sociology and 120 hours in the nursing arts. A short course in the arithmetic of solutions also is included.

The work in anatomy and chemistry is given intensively during the first eight weeks and microbiology and nursing arts are emphasized during the last eight weeks. This does not mean that all of the nursing arts are taught in eight weeks but that more class hours are given toward the end of the preliminary term than in the beginning. During the time that nursing procedures are being taught the students are on the wards from five to eight hours a week. Supervision on the wards during this time is in the hands of the nursing arts instructors. At present a short unit in psychology is being given early to stress laws of learning and methods of study and the remainder of the course is given after the students have covered the work on the anatomy of the nervous system. The classes in sociology are interspersed between the two parts of psychology.

After the students are capped at the completion of the first sixteen weeks, they are assigned to 7 hour shifts on the wards and have eight to ten hours in class weekly. These classes include: introduction to medical science, foods and nutrition, history of nursing, pharmacology and therapeutics. The work in medical and surgical nursing is begun along with diet therapy. The medical and surgical nursing continues into the second year and includes units formerly somewhat isolated such as dermatology, orthopedics and gynecology. Much of the work in medical and surgical nursing has been combined and paralleled with diet therapy. There is a decided advantage in this plan.

**The educational director, Jewish Hospital School of Nursing in St. Louis, pleads for integration of classroom work with experiences on the wards**

The organization of the subject material into units is responsible for including lectures on arthritis in the unit on diseases of the musculoskeletal system along with orthopedics. The unit on the respiratory system includes not only ear, nose and throat but also pneumonia, surgery of the lungs and other diseases of this system. The unit on the nervous system includes the medical aspects of such diseases as were previously included in neurology and also the surgical aspects of these diseases. Gynecology is taught as a unit in the major program of medical and surgical nursing.

### Holds Strategic Position

For the most part the same instructor conducts the nursing classes in these units and also supervises the case studies. In this way, she is in a particularly strategic position to bring about correlation as well as integration of subject material.

The organized ward teaching, including morning conferences, individual conferences, clinics and demonstrations, parallels much of the work in medical and surgical nursing and amounts to fifty hours or more a year. The second year students also study obstetrical nursing at a time when the majority of them are actually assigned to the ward. Classes and lectures in this subject are given twice a year to accomplish this correlation.

The senior year, partly given to affiliation in public health and communicable disease nursing, also contains the work in psychiatric nursing, 15 hours; professional problems, 20 hours, and pediatric nursing, 45 hours.

This program, then, is the general plan for the three years. For the most part changes consist chiefly in

placing more emphasis on the social sciences, of an increase in the applications of chemistry to nursing and household arts, emphasis on positive health and prevention of disease in the first part of nursing arts and a rearrangement and combination of courses in medical and surgical nursing.

This plan constitutes part of the groundwork for the main structure in the Jewish Hospital program of education, the functional experiences of the student nurse. The success or defeat of the whole program depends greatly on what kind of teaching is done either in the classroom or out of it. The entire faculty, which includes the head nurse, supervisors and all concerned with teaching, must understand what integration means and how it can be accomplished.

Integration must be the goal in the teaching of young students as well as in the teaching of the older ones. Facts often can be taught in connection with situations which are of definite significance to her. The unit in sociology, in which community resources are studied, can be of real import to the students if they actually contact centers in the city to make a study of amusements, means of transportation, schools, churches, organizations and later pool their findings in a class discussion. Frequently in such discussion, a definite knowledge of psychology, hygiene, microbiology and similar subjects can be brought out and related to the topic under discussion.

An added factor in the integration plan is the testing program. It is possible to formulate splendid sounding objectives for our courses and then not construct the examination so that instructors can find out whether or not the objectives have been achieved. Nursing schools have tested factual material rather than the probable reactions of a student to a problem situation in which she has an opportunity to use acquired knowledge or skill. To remedy this fault, it is suggested that schools examine students at the end of each year to determine how well integration has been accomplished.

It is not an impossible task to institute many of the suggestions in the Curriculum Guide. There must be much adjusting but it should be an adjustment and not an adaptation. The suggestions may need to be modified, but some change must be made in the teaching staff as well.

Nursing schools are faced with many difficulties. In the three year program, time is an element. It takes time for teachers to prepare themselves. It takes time and concentrated effort to plan different methods of teaching, such as the seminar method and the symposium, or an effective ward teaching program.

Another difficulty is that for the most part we are still working with young students who, because of their immaturity, need much in the way of guidance. In spite of the handicaps, there can be no doubt that decided advances can and are being made in the three year program.

# Medical Staff Promotions

CLINTON F. SMITH

IT IS not easy to find in hospital literature a concise statement of the duties and responsibilities of the doctors who constitute the various divisions of the medical staff. When we recently were forced to face this problem at Grant Hospital, Chicago, we drew up the attached rules for promotions in the medical staff. These were approved first by representatives of the medical staff and then by the board of trustees.

These rules provide several desirable features: (1) a definite system of promotion based on ability and loyalty; (2) annual appointment, thus giving an opportunity to weed out undesirable members with the least pain to them and to the hospital, and (3) recognition of the place of certification by national specialist organizations.

The new rules are as follows:

The constitution and by-laws provide for five divisions in the medical staff. These rules and regulations recognize the five divisions and suggest the following procedures to be observed:

Visiting Staff: We recommend that any physician or any surgeon in good standing in his medical society be eligible for membership on the visiting staff if he files an application blank, together with a signed pledge, with the administrator of the hospital. No physician or surgeon can hospitalize patients unless he files an application blank and signs the pledge.

Courtesy or General Staff: We recommend that all physicians and all surgeons who have been on the visiting staff one year or more and have hospitalized a number of patients in Grant Hospital of Chicago be eligible to the courtesy or general staff.

Associate Staff: We recommend that a physician or a surgeon may be eligible to a medical department on the associate staff after he has been on the courtesy or general staff one year or more and has proved his ability in his particular department and has shown his loyalty to Grant Hospital by hospitalizing a number of patients.

Senior Attending or Active Staff: We recommend that before a surgeon or a physician be eligible for promotion to the senior attending or active staff he obtain certification from the national board of his department of medical service.

Consulting Staff: We recommend that the consulting staff be composed of men who have rendered distinguished service in the field of medicine.

We recommend that the courtesy or general staff, the associate staff, the senior attending or active staff and the consulting staff comprise the mailing lists for all important announcements from the medical staff and the hospital staff.

We recommend that at the end of the hospital year, June 30, the lists of staff members be revised and that appointments and reappointments take place at the board of directors' final meeting of the year and that each physician or surgeon be notified by letter of his appointment or reappointment.

# Three Safeguards for Infants

**Left: The humidifier now in use in the nursery. Right: Two ultraviolet quartz lights, one in an inverted bowl and the other a wall bracket fixture. Between the two is one of the humidifiers.**

L. C. VONDER HEIDT

**Increased humidity in the nurseries, control of visitors and the use of ultraviolet lamps are improvements in the care of new-born infants that give protection at West Suburban Hospital, Oak Park, Ill.**

LAST year when Chicago hospitals were confronted with a serious situation in their nurseries, I tentatively suggested a twelve point program. Since then the hospitals have been overwhelmed with perhaps 112 rules, mandates and regulations. A considerable number of these are good and the net result doubtless will be marked improvement in Chicago and elsewhere.

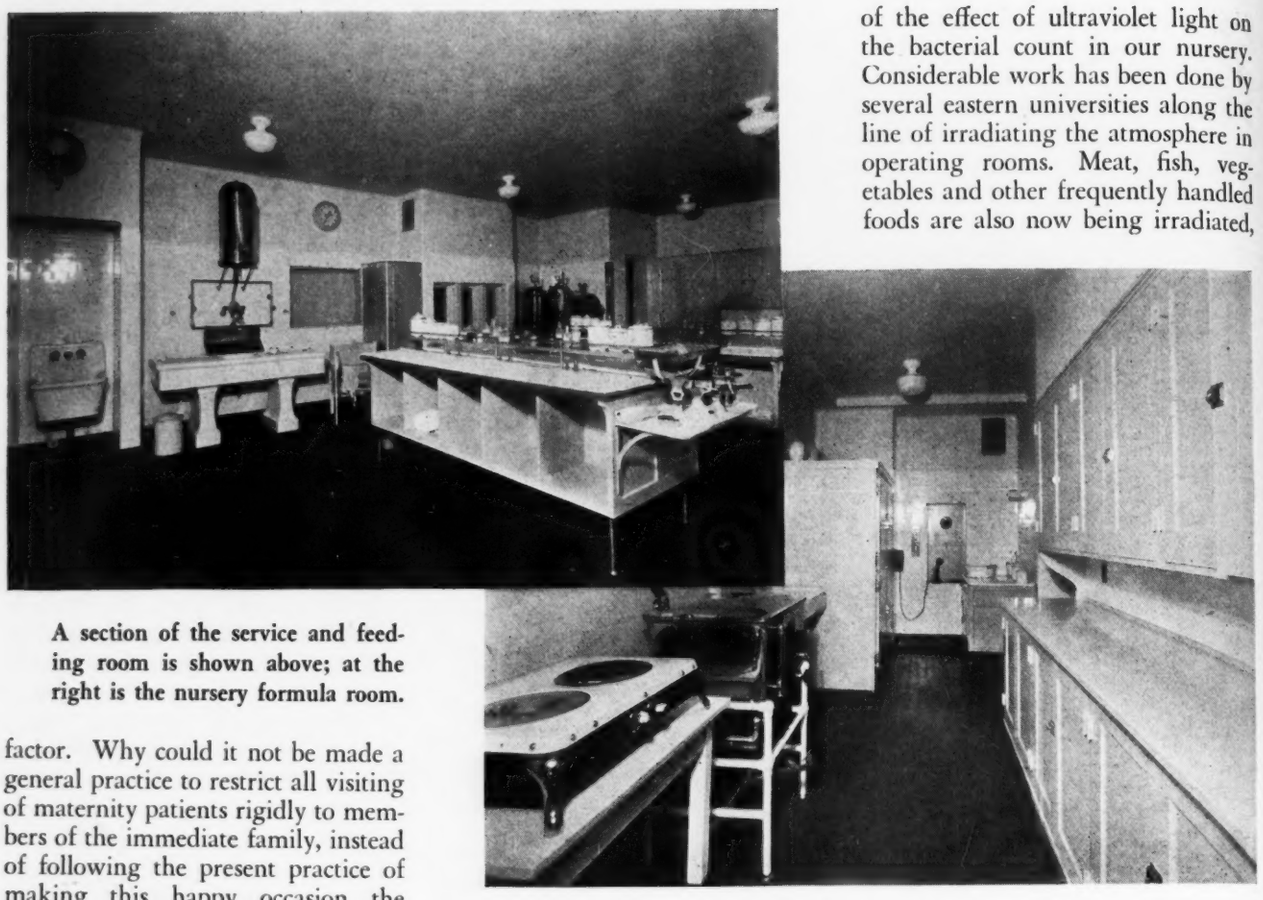
Everyone knows that one of the most vulnerable points in a hospital is the maternity and nursery section. Most hospitals have had some unfortunate experience or other. We did in the winter of 1928-29—primarily intestinal complications with respiratory involment in some cases. After several weeks of discussion and investigation there were numerous conclusions. I was not wholly convinced, however.

Sometime previously I had read a foreign medical journal that called attention to the absolute necessity of maintaining humidity for the new-born at least during the first ten days or two weeks after birth. The fundamental thought was that these infants come from a moist place and we dare not take away this humidity.

With this in mind, I took occasion to check the humidity in our nursery and found a maximum reading of 17 per cent, a minimum of 12 per cent and an average for a week of 15 per cent. It was apparent immediately what this meant! Steam heat had removed nearly all humidity. Visualize the condition of your own nose and throat on attempting to sleep, perhaps only for eight hours, in a room under similar conditions with the temperature at 80° F.

I quietly took one of our old humidifiers from the surgery and raised the reading to between 30 and 40 per cent. Over a period of nine years, with almost 13,000 babies, we have had no reoccurrence of this serious difficulty. Today we evaporate 15 gallons of water in our nursery each 24 hours during the winter or heating season.

The control and education of maternity visitors are a second vital



**A section of the service and feeding room is shown above; at the right is the nursery formula room.**

factor. Why could it not be made a general practice to restrict all visiting of maternity patients rigidly to members of the immediate family, instead of following the present practice of making this happy occasion the signal for a Roman holiday on the part of every friend and acquaintance? We endeavor to teach visitors by intensive individual instruction by our nursery supervisor through each mother that there must be no handshaking, no sitting upon or leaning against beds and absolutely no contact with visitors.

The handshake we consider deadly. Visualize a visitor stepping in after hanging on to a strap or handrail in a bus, street car or some other public conveyance, shaking hands with a mother who perhaps in a few minutes may have her baby brought to breast. Then picture a dehydrated baby with a mother fondling eyes, nose, mouth!

Our third step concerned air-borne bacteria. During the last six weeks we have carried on a careful study of the effect of ultraviolet light on the bacterial count in our nursery. Considerable work has been done by several eastern universities along the line of irradiating the atmosphere in operating rooms. Meat, fish, vegetables and other frequently handled foods are also now being irradiated, but I believe this application to the nursery is pioneering a new field.

We placed a series of agar plates at crib height under numerous conditions—ultraviolet lamps off and on; dark days, days with sunshine; windows open, windows closed; morning and afternoon exposures, and exposures with attendants wearing masks and without masks. The reduction in the bacterial colony count by irradiation was amazing. We approached this theory with some skepticism and were pleasantly impressed by the favorable result.

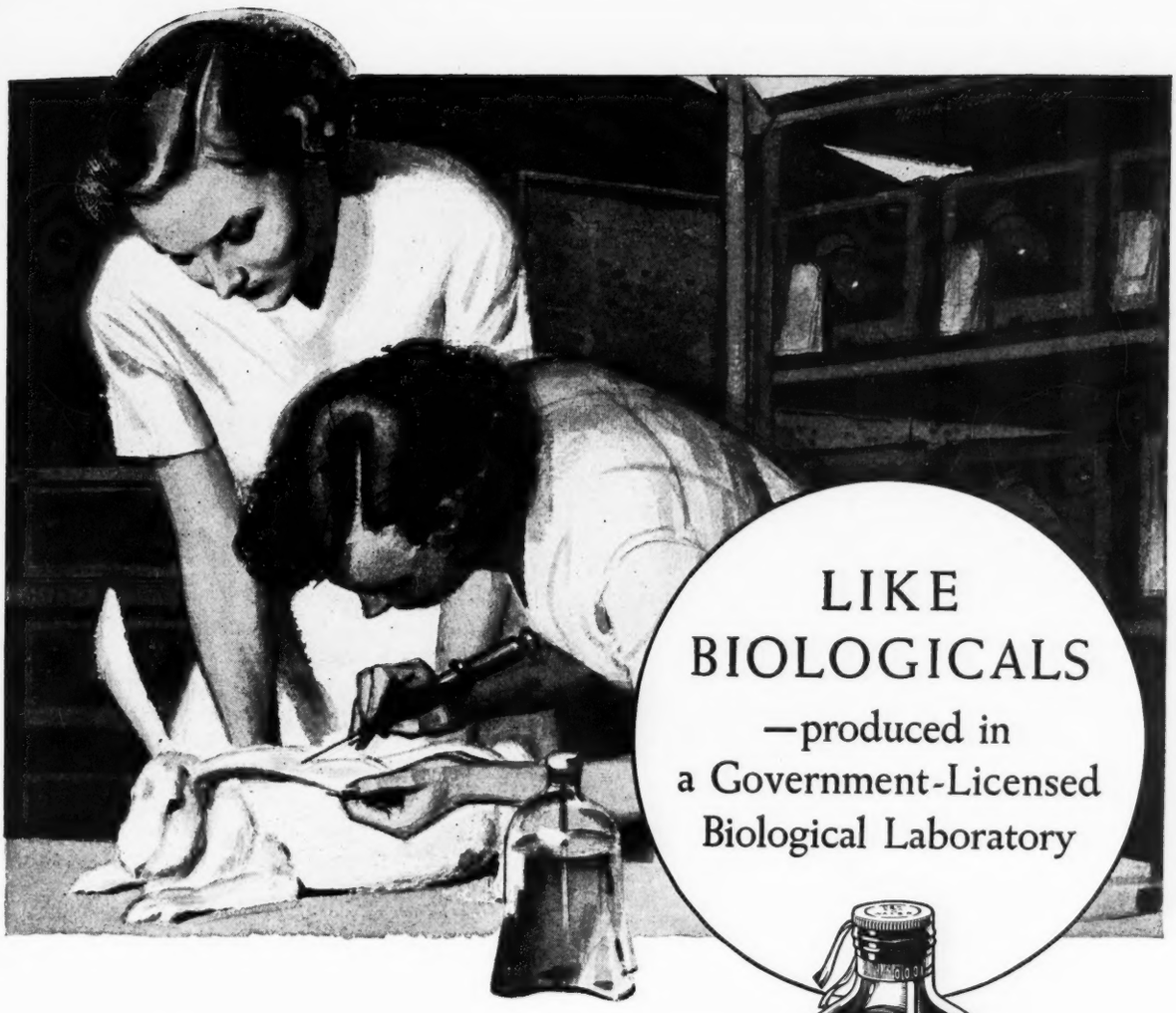
We have a 24 inch horizontal ultraviolet unit placed in the darkest or north section of our nursery, projected upward about 6 or 7 feet above the floor and about 5 feet from the ceiling. There is absolutely no danger to infants or attendants as ultraviolet rays must be direct to be effective. One unit of this type is maintained to irradiate the atmosphere in a room of 10,000 cubic feet. The room in which we placed this unit contains approximately 6000 cubic feet.

While we have not as yet concluded all phases of our experiment,

**Table 1—Effect of Ultraviolet Exposure on Air-Borne Bacteria**

*Number of Colonies Found on Agar Plates After Various Exposures*

| *Date* | *Condition* | *Length of Exposure* | *N.E. Nursery (With Ultraviolet)* | *W. Nursery (Without Ultraviolet)* | *Service Room (Without Ultraviolet)* |
|---|---|---|---|---|---|
| 3/20 | Lights on Continuously..... | 40 minutes | 8 | 12 | 21 |
| 3/24 | Lights on Continuously..... | 40 minutes | 9 | 32 | 85 |
| 3/29 | Lights Off for 24 Hours Prior to Exposure..... | 40 minutes | 51 | 33 | 14 |
| 3/29 | Lights Off 1 Hour Prior to Exposure..... | 130 min. (p.m.) | 20 | 10 | 35 |
| 3/30 | Personnel Masked Entire Day (Except Doctors)..... | 100 min. (p.m.) | 20 | 31 | 15 |
| 4/6 | Just After Cleaning (High Wind)..... | 60 minutes (a.m.) | 16 | 22 | 72 |
| 4/6 | High Wind..... | 60 minutes (p.m.) | 7 | 5 | 9 |
| 4/7 | During Cleaning (Calm Day). | 85 minutes (a.m.) | ..... | ..... | 55 |
| 4/7 | Calm Day..... | 60 minutes (p.m.) | ..... | ..... | 18 |



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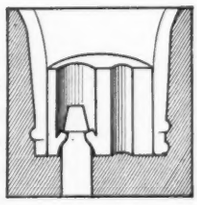

*Only one part required!* —A connecting tube which is supplied with each case of Saftiflasks . . . Patented soft rubber stopper fits any connection tube . . . Connection tube becomes integral part of your injection outfit. No loose parts to wash, sterilize, and reassemble. No involved technique, with resultant multiple sterility hazards.

we are fully convinced that there is real merit in this protective feature. We will shortly equip our three main nursery units, as well as the service and formula rooms for ultraviolet irradiation. Current consumption is small and the only upkeep will be the occasional replacement of a mercury tube.

Dr. Eugene Piette, our pathologist, directed the bacterial investigations with the folowing comparative results:

The preliminary experiments were set to establish the influence of ultraviolet light on the number of bacteria in the nursery, plain agar plates being exposed at various distances from the light and in rooms without the ultraviolet light. When turned on the ultraviolet lamp burns continuously. Results of these experiments appear in the accompanying table.

Findings in the first series of tests (March 20, 24 and 29) show an exceptionally favorable comparison in the number of colonies. The days were bright and cool and the windows were partly open after the first day, but not in the vicinity of the plates (except in the west nursery).

In the second series of experiments (March 30) all nurses and personnel, with the exception of the attending physicians, wore masks the entire day and plates were exposed in the afternoon.

Masks would seem of little or no influence. In fact, it always has been our contention that the masks worn by nurses over a long period constitute merely a spray for bacteria rather than a protection. It is our belief that a nurse taught to breathe with discretion away from a patient is less hazardous. The influence of ultraviolet rays in this test are less marked, but we find this was a bright sunshiny day with sunlight pouring through the quartz glass windows in the west nursery and service room, whereas the northeast nursery has only a north exposure.

It then became apparent that another factor influences the bacterial count, possibly the time of day. Morning is the busy time in the care of patients, with visits of attending doctors and cleaning procedure; the afternoon is much quieter.

A cloudy day with a severe snow storm and high wind was chosen for the third series of experiments (April 6), which also appear in the table. These findings were so striking that the experiment was repeated the next day in the service room. This day was cloudy, with snow on the ground and little wind.

The extreme variation upwards in the number of colonies in the service room on several occasions we ascribed to the fact that this is the room in which we assemble groups of mothers for demonstration of infant care, these patients being admitted through another door. We also investigated the cleaning procedure and materials used for this purpose. Since our service room is separate but connected with the nursery proper we expect a higher bacterial count. This also is the room in which babies are bathed, changed and clothed.

We plan to carry on further investigation with ultraviolet light in every section of the nursery and this should prove most enlightening.

It is necessary to equip these ultraviolet units for the nursery with filter jackets to eliminate the ozone odor, which we understand has some unfavorable physical effect.

Air conditioning offers some hope for providing the proper ratio of humidity, but to date we have no guarantee as to maintenance of the required humidity and temperature.

With the application of the foregoing scientific and mechanical protection, as well as the mandates for improved practice generally, I can see where "bargain-counter" obstetrics are now on the way. Certainly, some of our competitive methods were out of line and not in keeping with hospital or professional dignity.

A floor plan of our nursery facilities would show location of the various units, ultraviolet lamp, northeast nursery, west nursery, service room, sun exposures and quartz light window glass.

As a lay superintendent, I give full credit to the medical profession for the accomplishments and great progress in scientific maternity care, but we administrators carry a moral responsibility for the physical surroundings that we dare not shirk.

# Light Reflection

GLADYS BRANDT, R.N.

PROPER control of light reflection on desk surfaces in the office at Cass County Hospital, Logansport, Ind., has entirely eliminated office employes' complaints regarding eyestrain caused by glare.

Our desk tops are of mottled brown and tan linoleum and the clerks' working area is covered with glass. For years we had used a shaded lamp which was unattractive in appearance and provided inadequate lighting. This we replaced with two smart desk lamps, one with a pedestal base and the other designed with an adjustable arm and with the bulb so placed in the socket that the light is diffused.

The clerks were delighted. Yet after a few weeks three of the four persons who worked in the office complained of poor vision and eyestrain. These three wore glasses. Blame, of course, centered on the new lamps.

We complained to the company, whose reply was as follows:

"A glass desk top reflects approximately 75 per cent of all the light which strikes it and when the glass desk top is used on a desk of light colored wood, the reflection is intensified about 10 per cent. If papers are used underneath the glass, the reflection is increased approximately 5 per cent. Naturally, the more light there is striking the desk, the greater will be the amount of reflection.

"As the construction of the light is such that the light is completely diffused, there is no glare unless it strikes a reflecting surface such as glass. This can be completely eliminated by the use of linoleum desk tops or desk pads, which do not reflect the light rays."

The glass tops were removed. To make the lighting even more satisfactory 100 watt blue bulbs were installed to replace the clear bulbs.

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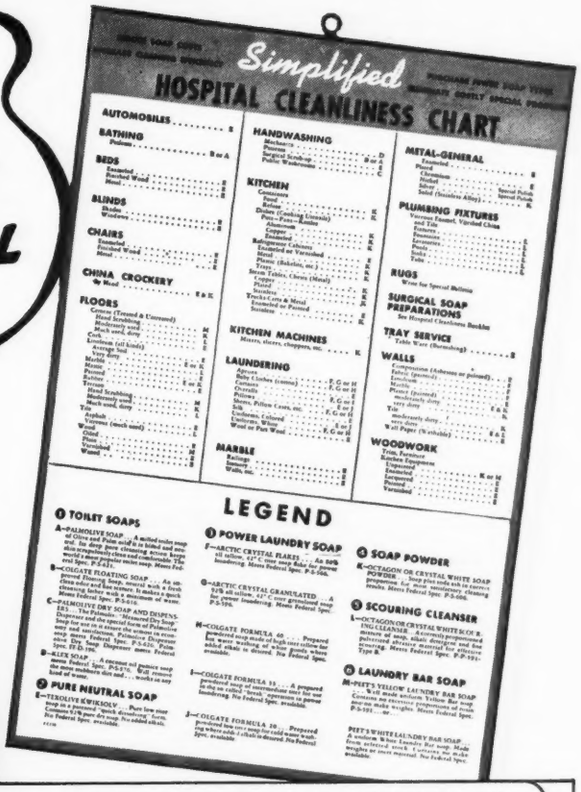


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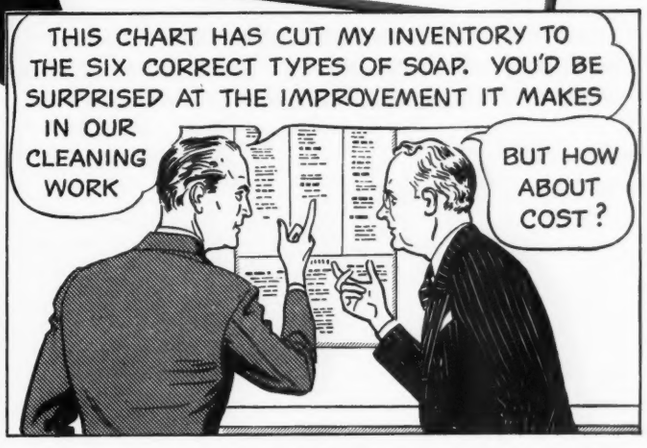


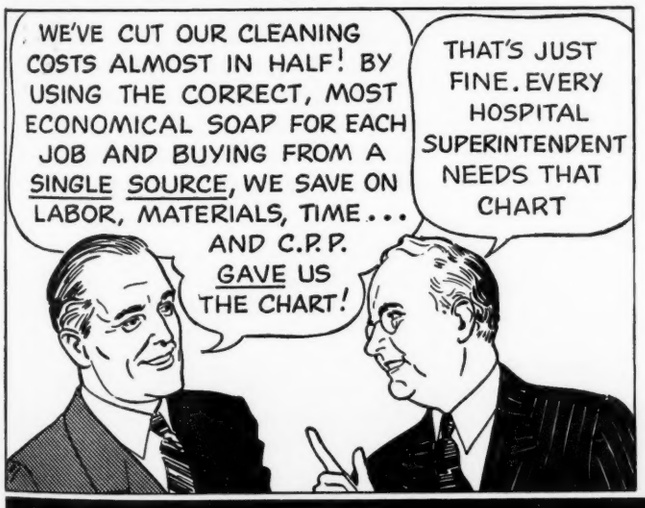


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# Quality Painting Pays

J. D. JENKINS, Ph.D.

FOUR economic and financial factors will largely dictate the painting and maintenance policy of the hospital. First and probably most important of these is "eye appeal," that indefinable something which tells the patient and his visitors that the management is efficient, thoughtful, careful and scrupulously clean. The entering patient is usually uneasy and a bright, cheerful, homelike appearance will reassure him that every effort will be made to see that he is comfortable.

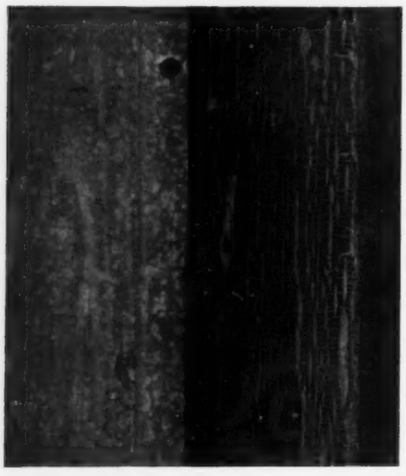
Mr. and Mrs. John Public unconsciously judge largely by first impressions. If the decorating is in good taste and is neat and clean, they will expect the same high quality in those things that do not meet the eye. This fact is widely recognized in a detached way, but habit and tradition often have hampered its application.

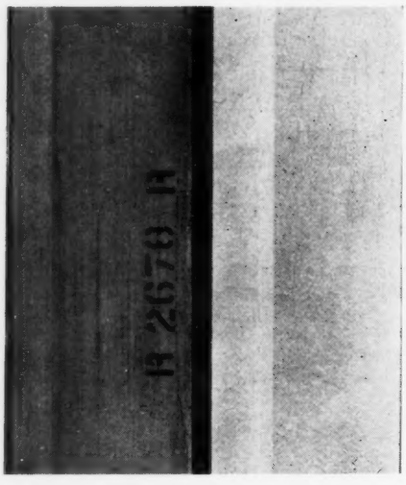
The importance to the business office of favorable public sentiment is obvious. It immediately affects the amount of business which comes to its doors and the contributions of money and supplies upon which most hospitals must lean for part of their support. In spite of this, too often one of the first things that is reduced when financial troubles arise is the painting and decorating budget.

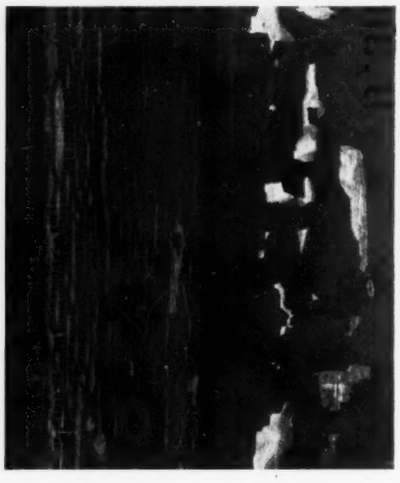
The scheme of decoration, the choice of colors and the sheen on the paint will determine the general appearance achieved. Economy of operation will be greatest with all-over colors in neutral dark shades. A little additional trouble at scarcely any greater cost will allow more attractive shades with possibly a lighter ceiling color which, with high ceilings, may be brought down on the sides to a simple stencil border.

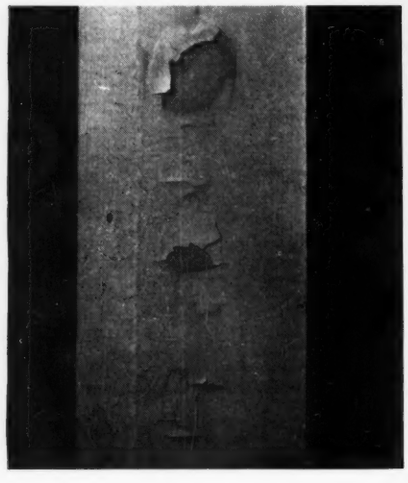
Deep and pronounced wall colors should be avoided, particularly in patients' rooms, as the effect upon the patient is irritating. Such colors as reds and oranges are too vigorous and stimulating for most people, even when in the best of health. The colors must not intrude, but should be soothing and suggest comfort and quiet.

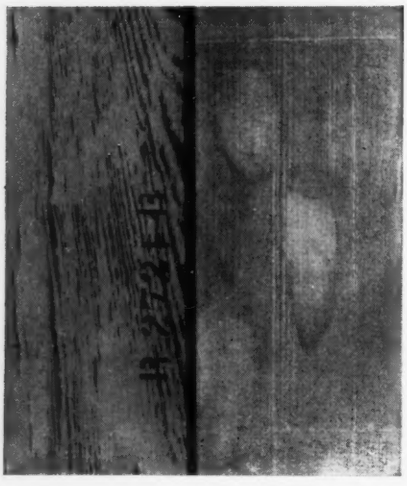
Patients generally should have sunshine and warmth, so that rooms that get little or no direct sun can well be finished in a clear suntone shade, while those that get overmuch may require a grayed and darker suntone, or cooler colors such as pale gray greens, gray blues and blues. If it is desired to maintain about the same scheme of color appearance throughout the hospital, then the rooms nearest northeast should be allowed clearer tones with more sunlight color in them, while those southwest











**Examples of poor paint and indifferent workmanship. Left, above: Results of water spotting on exterior wood surfaces. Left, center: Checking and wrinkling on exterior surfaces. Left, below: Grain cracking and peeling and chalking. Above: "Alligatoring" and blistering and peeling. Right: Another good example of blistering.**

# GALL-BLADDER STONES

## *Visualized with* IODEIKON N.N.R.

**(MALLINCKRODT)**


Hodges finds cholecystography valuable as an aid in gauging gall-bladder function, in determining the presence or absence, character and number, and location of gallstones. (Amer. J. Surg. April 1938.)

Gall-bladder shadows of clarity and density are furnished by IODEIKON* (Mallinckrodt). Pure tetraiodophenolphthalein sodium, as introduced to the profession by Mallinckrodt, the chemical is now recognized in the U.S.P. IODEIKON is conveniently administered orally; it may also be used intravenously.

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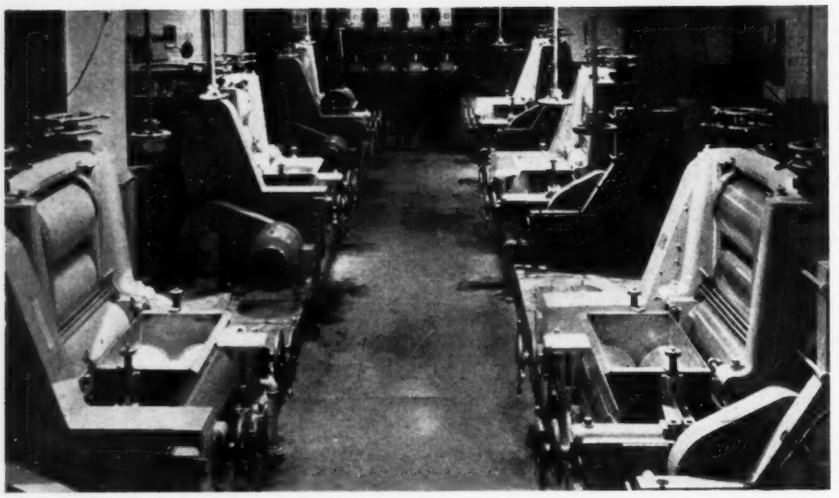


**Mills in which color and oil are ground into paint in a modern factory.**

need to be darkened and grayed by comparison.

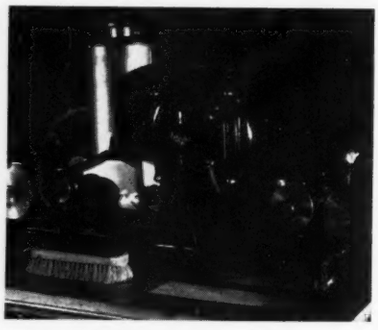
The proper choice of color costs nothing, but it pays big dividends. Some of the leading paint companies now maintain color service departments with staffs of experts in the field of color and the science of color use; their guidance is available in planning color selection and schemes of decoration.

The finishing of the woodwork is another subject that needs careful thought. Cost of maintenance undoubtedly will be lowest if the woodwork is stained and varnished, but appearance frequently will be decidedly improved if it is enameled either slightly lighter or slightly darker than the walls, or in a harmonizing shade. The more nearly the shade approaches the wall color the larger the room will seem.

It will be well worth while to check up on the light reflecting value of the colors you select. A few of the leading paint companies now furnish color cards on which the light reflecting values of the colors are given. The saving in electric light bills by the use of paints of high light reflectance is appreciable. For instance, a room painted in ivory, with a light reflecting value of 80 per cent, will require about one-third the electrical energy to maintain the general illumination at a given desired level as a room painted in a medium green, for example, with a light reflection value of 40 per cent. Moreover, the type of illumination produced by lighter walls is more desirable.

Rooms with dark walls have sharp contrasts between light and shadow, whereas rooms with light walls have a softer all-over illumination. Light ceilings make it economically feasible to use indirect lighting, which is out of the question with dark ceilings.

Pick your paint only after careful investigation. Never buy a paint because the price per gallon is low, because paint cost is one of the less important elements in painting maintenance. The cost of labor in painting will average about three times the cost of the paint and the difference in cost of first and second quality product is small in comparison with the cost of repainting prematurely. Paints differ widely in their resistance to soap and scrubbing and in their ease of washing. Paint must stand up under repeated washings in order to reduce costs.



**A mechanical scrubbing machine for measuring the resistance of the various paints to washing.**

The frequency of repainting will depend on how frequently it is necessary to wash the walls. Paints differ greatly in the rate at which they gather dirt. Glossy paints collect dirt more rapidly than flat or matte paints, while semigloss paints are intermediate. On the other hand, flat paints, once they are dirty, are generally more difficult to wash and clean than glossy paints, while low sheen paints are usually better than either. For these reasons, and because low sheen paints have a pleasing appearance, they are popular for interior finishing in hospitals and sanatoriums. Woodwork enamels should be examined, in addition, for leveling and covering qualities. A cheap coarse paint or heavy coats will fill up the fine molding in the woodwork and age its appearance prematurely.

The paint should dry rapidly and have a minimum of odor, because slow drying or strong odor in paint will increase the length of time a room must be taken out of service. These properties should not, however, be obtained at the sacrifice of washability. Modern paints are much improved in drying and odor over the older materials. Products are now available which dry rapidly enough that pictures may be rehung the same day. All newly painted rooms should be ventilated as much as the weather permits without allowing the temperature to fall much below 70° F.

Just as the cost of labor is a major factor in the cost of painting, so also the skill of the painter is of paramount importance in the quality of the job. The best of paint carelessly and improperly applied is little better than the cheapest paint put on with skill. Good workmanship is as essential as good paint. There are, however, many experienced and reliable painters and decorators who can do a first class job at reasonable cost.

Good workmanship requires good tools, so the experienced painter will avoid the use of cheap brushes. He knows good brushes well cared for will pay for themselves in better work, saving in paint and saving in time. Brushes should be cleaned as soon as the work is finished and care should be taken in particular to see that the base or heel of the brush is free from paint, as dried paint reduces effective bristle length and so impairs usefulness.

The maintenance of building exteriors offers some particularly important problems. Face brick must be continually inspected and watched and, if incipient deterioration is

noticed, it should be repaired immediately. All possible precautions should be taken to prevent entrance of moisture into the walls and seams. If the brick is not hard burned, a clear waterproofing treatment may be necessary.

Concrete surfaces, particularly where they are subjected to excessive moisture, are a source of trouble. They should be frequently inspected and, if dusting or hair cracking develops, they should be either painted with an appropriate paint or waterproofed with a clear waterproofing liquid. Metal surfaces require particular care. Keep the surface protectively painted before corrosion, as once rusting has started it cannot be so successfully combated.

High maintenance costs do not result from painting, but from expensive replacements. If rusting has started be sure that, before repainting, all traces are removed by vigorous wire brushing. Then apply an inhibitive primer and follow with at least two coats of metal paint. Wood surfaces should be thoroughly protected against water absorption. Once the paint film is broken, swelling and shrinking of the wood rapidly damage the finish and the result is peeling and flaking. Wood subjected to such action then rapidly disintegrates and decays.

Interior finishing has its own pitfalls. In an attempt to get the original paint job past inspection, faulty or dangerous practices are sometimes resorted to. Plaster is occasionally painted too green, improper sizing materials may be used, it may be subjected to moisture from the back side because of improper construction or it may be nonuniform and spotty.

These defects result in peeling, blistering and spotty appearance or in poor drying. Glue and varnish sizes and varnish base wall paints are not recommended because too frequently they cause peeling. Oil base paints are now available that have sealing properties equal or superior to such materials without these disadvantages.

Efflorescence frequently causes trouble in plaster painting. This defect results from capillary transfer of soluble salts, usually sodium or magnesium sulfates, from insufficiently fired terra cotta tile into the plaster. Its effect is to soften and crumble the plaster and to push the paint loose from the surface. At times white feathery crystals appear on the surface of the paint. The remedy is to separate the plaster from the source of the soluble materials so that transfer cannot occur.

The refinishing of hospital furniture is a job of considerable importance. Chairs, dressers, tables and other furniture must be kept neat and clean. In a hospital with 300 or more beds this work requires constant attention.

This type of painting is best done with a spray gun. A good quality enamel should be selected for use on furniture; it should be high in covering power, with a flexible film that does not become brittle and chip with age. A fairly good gloss is desirable, but a brilliant gloss will show mars and scratches too prominently and have a cheap appearance.

The experienced painter will avoid too heavy applications of paint, particularly on wicker furniture, as they fill in the pattern and rapidly detract from appearance. Wicker pieces preferably should be sprayed, both for this reason and to save work.

New and improved products are being developed by the paint industry and new fads and fancies are continually seeking recognition, but the best formula for long-time satisfaction still is careful choice of colors, first quality materials, skilful workmanship and constant watchfulness.

# Plastering and Patching

R. G. DEMPSEY

ONE of the most important functions in the maintenance of hospital buildings is refinishing walls and ceilings. This includes patching any broken plaster as well as painting or decorating, as walls must be in good condition before decorating.

The plaster should be patched first. Wood lath was used almost exclusively in the older buildings. Quite often the lath has broken loose causing the plaster to crack and fall off. The first step, then, is to remove all loose material and to renail or replace all laths affected. When metal lath has been used, cleaning off the old plaster usually will be sufficient although it may be necessary to renew the lath in some cases.

Moisten the area to be patched with water. This can be done with a calcimine brush or by dashing on the water with a small broom. Care must be taken to moisten well over the edges. Then make a mixture of 2 parts of fine screened sharp sand to 1 part of cement plaster with hair or fiber in it. This should contain just enough water to make a mixture that will adhere to the surface. By experimenting the necessary amount can be easily determined. Using a steel trowel, place this mixture on the wall evenly over the surface to be patched and leave it down or back from the finished surface about ½ inch. This should be allowed to set twenty-four hours or more until it has become hard.

If the wall has a sand finish, equal parts of sand and cement plaster should be used for the finish coat. The same kind of plaster that was used in the first coat may be used by removing the fiber or hair through a fine screen. With the steel trowel, this can be placed on the wall making it somewhat thicker than the surrounding plaster. By using a straight-edge (any piece of board long enough to cover the patch and 4 or 6 inches wide) to rub across the surface, the patch will be made even with the wall.

A float may be made by using a straight board 4 by 12 inches. The float should have a handle by which to hold it. This board should be covered with a piece of carpet and used to go over the surface with a rotary motion.

If the wall has a smooth finish, put on the first coat as described. For the second coat, make a mixture of slacked lime to a consistency of putty to which has been added a small amount of gauging plaster, about one-thirtieth as much as lime. The lime will not harden otherwise. The job must be finished with the steel trowel so that the surface will conform with the rest of the wall.

# Work Ahead for Housekeepers

DORIS L. DUNGAN

THE last five years have brought rapid changes in hospital housekeeping apparent to us all. Whether or not this progress is maintained during the years to come rests solely with those of us now responsible for what is recognized as one of the most important departments in our voluntary hospitals.

Having demonstrated, to administrators and trustees alike, the need for trained women in housekeeping posts, we must substantiate their new faith in us and continue to develop their respect and confidence in our capabilities. It constitutes a challenge which cannot pass unnoticed.

### The Public Is Impressed

Housekeeping has outlived the period in which merely adequate institutional maintenance and upkeep are implied. In its broader phases it constitutes today the creation of an atmosphere that is at once inviting and compelling—the friendly feeling you detect the minute you step inside the front door. It may be manifest in the cheery "Good morning" of the maid who is sweeping the vestibule or in the solicitous warning of the porter who is mopping up the hallway: "Be careful, please, where you walk; the floor is slippery." It may even be apparent in the vase of carefully arranged flowers standing on the reception desk. In these or other details you will find the answer. By this time, however, a favorable impression has been made—"There is something about this hospital I like."

Hospitals, generally, have been woefully indifferent to the effect of their sterile walls upon the lay public, we are told. To win the friendship, support and confidence of everyone who enters they must extend a welcoming hand, literally or figuratively speaking. Who will say that this lack does not reflect merely the absence of an efficient hospital housekeeper?

Perhaps the term "housekeeper" is limited and not sufficiently descriptive of the many sides to the rôle as it is being enacted today. On the other hand, it has a certain dignity handed down through the years that many of us would not like to see discarded. Yet we must recognize that the housekeeper has forsaken her apron and chain of clanking keys for an immaculate white uniform or neat business costume and conducts her affairs according to business procedure.

We have learned much; there still remains much for us to learn. How successful we are in educating ourselves to the many complexities of hospital problems rests with us individually and collectively, that is, in our association activities. Surely no one can say that the opportunities awaiting us are not greater than ever before. This is attested by the constantly increasing number of hospitals in search of trained women to assume responsibility for their housekeeping procedure. In this field at least the present supply is inadequate to the demand.

Even before considering an educational program we should first analyze our own attitudes toward our work. Are we by nature fitted to it? Does it offer us something beyond merely a fair living? Do we see in it opportunities to express ourselves either through our executive ability, our creative sense, our artistic talent or our personality?

**In her first official message the new president of the N.E.H.A. advises executive housekeepers to continue their professional advancement through education, because of the versatility required of them in their positions**

Let me emphasize personality as being perhaps the most important of all. There is some hope of acquiring business judgment and art sense, and unquestionably our imagination develops with practice. Personality, however, is something we either have by nature or we lack. Probably its presence or absence is more quickly sensed by the outsider than any other one attribute. The maid we referred to is not going to smile her "Good morning" unless someone customarily greets her in similarly friendly fashion; the porter is not going to be solicitous about our slipping on his wet floor if no one cares about his own welfare.

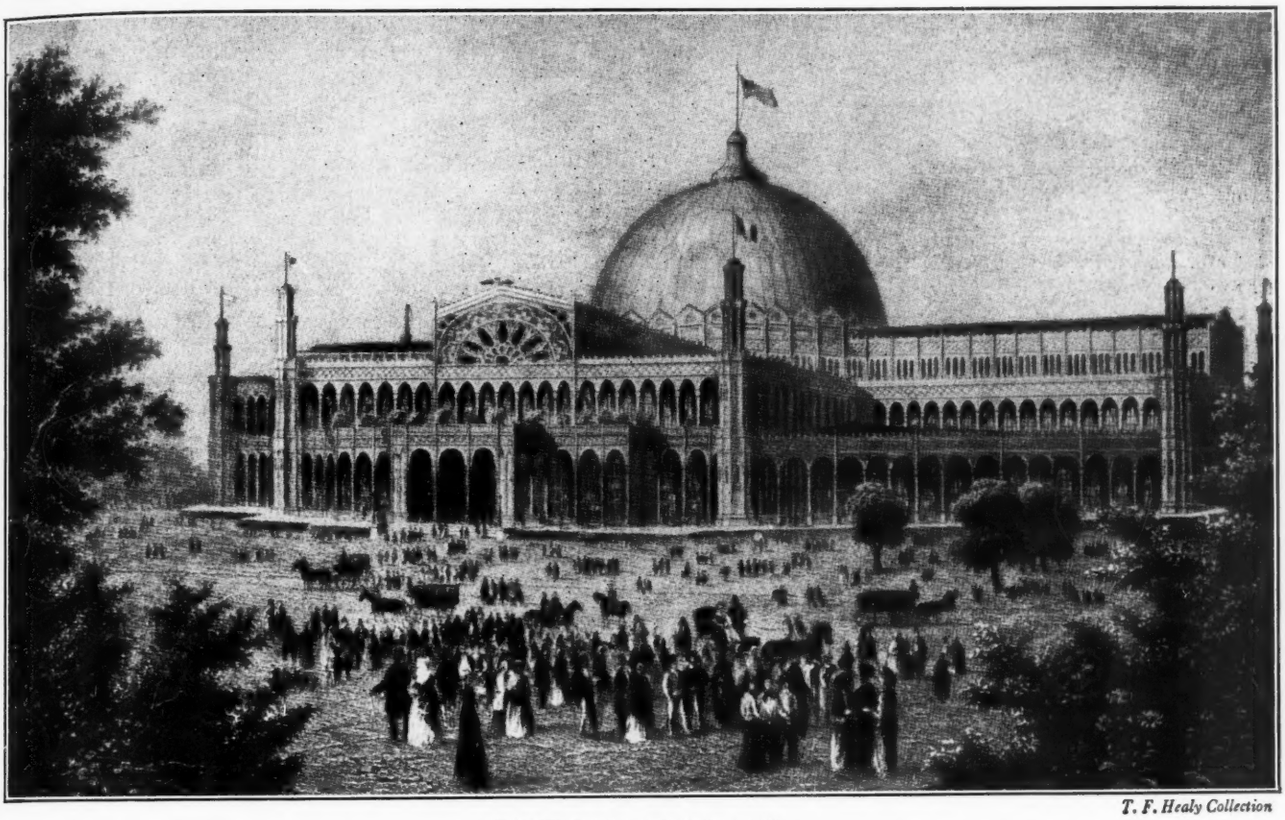
No hospital employe is going to be courteous to others if he, in turn, is not treated with consideration. Much of the atmosphere that the housekeeper can hope to achieve in her institution lies in her own personality and her attitude toward her employes.

### Acquiring a Background

Once we are convinced that housekeeping is our forte and it is something we would rather do than anything else, we are able to take the next step and consider the question of where and how we can obtain the necessary background on which to draw for our professional advancement. In this we are aided by the increasing number of opportunities for study provided in courses on institution management, purchasing, selection and handling of personnel, interior decoration and similar subjects, all of which are essential to modern housekeeping procedure. Universities and adult educational courses—manufacturers even—represent sources of information that make accurate knowledge entirely within the range of every hospital woman no matter in what part of the country she may be located. The only requisite is that she be willing to devote a definite portion

# Since America's First World's Fair

## *Hospitals Have Used Webb's Alcohol*



*T. F. Healy Collection*

BRYANT PARK, NEW YORK—1853

[ On July 4, 1853, the first World's Fair ever held in America was opened in the famous Crystal Palace by President Franklin Pierce. The two-story iron and glass structure was octagonal in shape with eight 75-foot towers at the angles, dominated by the center dome which rose to a height of 148 feet. ]

MOST achievements in medical science to be exhibited at the New York World's Fair next year were little more than dreams 85 years ago when America held its first World's Fair. X-rays were unheard of; ether as a surgical anesthetic, demonstrated in 1846, was not fully accepted; insulin had not been discovered; to mention only a few.

Undoubtedly many of the men and women who advanced the frontiers of medical knowledge during the past century did so with the aid of Webb's alcohol. For high-quality pure alcohol was essential in a majority of the developments . . . and, since 1835, the name of James A. Webb & Son has been a symbol of quality.

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of her leisure to some educational project.

Summer courses provided by our leading universities and colleges have proved of great benefit to those who have registered for them. Such special work may be accomplished at a sacrifice of vacations, to be sure, but what matter, for one year anyway! The thrill of acquiring new ideas and the stimulation that comes through personal contacts with others more than compensate for any loss of leisure. Evening courses that may be available during the winter season likewise afford excellent facilities for acquiring a sound ground work. Surely spending an evening or two each week in the pursuit of definite knowledge will never be regretted.

Now we come to another educational opportunity that is available to every housekeeper: participation in association activities. During the last three or four years we have had many examples of what can be accomplished along educational lines by various local chapters of the National Executive Housekeepers' Association. Only a start has been made, however, in the direction of sponsoring a self-sustaining series of instructional meetings. Concerted action is necessary to stimulate interest in making these events not only socially entertaining, but of real educational value.

It is not a question of whether the individual can afford to give the time to association work but whether she can afford not to become associated with all forward looking movements identified with her professional life.

"But I'm too tired at the end of the day's work," is an excuse frequently voiced, or "I'd like to help but I just haven't the time." The truth is that most of us can find time for that which we really want to do or that which we deem essential. The chances are, too, that any sincere effort on our part to improve ourselves and raise the standard of our work will earn the sympathy and interest of our superintendents.

Looking further we find the type who proudly proclaims herself an individualist and who sees no reason why she should participate with others in group projects.

"Why should I help them run their jobs," she asserts. "I've learned what I know by hard experience."

She may not realize that it might have been easier had others lent a helping hand; also that as proficient as she may be, there still may be something left for her to learn from others. After all, we get in proportion to what we give.

Discussion of common problems, round-tables, talks on a number of carefully selected topics by qualified speakers will prove a most effective means of education. All that is required is unselfish interest in promoting higher standards in our work. The start of the fall session offers another chance to each and all of us, a fresh beginning with which to prove ourselves. We have gone far. We will go farther, granted the cooperation of every woman in the field. Having already demonstrated the importance of housekeeping in its modern interpretation in every hospital large and small, we must properly equip ourselves. The hospital needs us. We need the hospital. Let's lend every effort to make of ourselves true hospital women.

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# Less Leniency With Linen

ELIZABETH F. HARRIS

LINEN control is a compelling question to housekeepers for economical operation of the housekeeping department depends on the effectiveness of this control.

Assuming that the hospital linen has been selected with care, the bases for any system of control include a linen inventory at least twice a year, careful marking and a workable plan for discarding worn pieces and making replacements.

At Presbyterian Hospital, Denver, we find it economical to have all the linen for patients marked with the name of the hospital only. In this way one floor does not get more than it needs. The following ratio has been worked out in deciding how much linen is necessary to meet the demands for linen per bed: 7 sheets, 7 pillow cases, 3 spreads, 3 bath towels and 6 face towels. Our first step was to bring the inventory up to this amount for each bed.

Linen for special departments, such as the nursery, operating rooms and x-ray, is marked with the name of the department and handled separately.

Our method for distributing linen requires that each floor supervisor plan the amount of linen she will need for the following day and requisition this amount. We have worked out a fairly definite schedule, which calls for one sheet, one pillow case and one face towel for each patient each day and one spread, two sheets, one bath towel and one face cloth for each patient on Wednesday and Sunday only.

When preparing the requisition, the supervisor is permitted to add to this amount what she thinks will be necessary for emergencies. We make it a point to observe the foregoing linen schedule only when it meets the needs of patients. Another important rule is that no clean linen is to be used, unless absolutely necessary, on the day the patient goes home. The requisition is sent to the office of the superintendent of nurses to be checked and signed before being taken to the laundry.

Linen is delivered to the floors between 3 and 4 p.m. A nurse checks the requisition against the amount of linen that is delivered to be sure that it tallies. Deficiencies are noted before it is signed. The fresh linen is then placed on the shelves of the linen closet without wasting time in refolding.

Each afternoon at 3 o'clock a student nurse places the amount of linen needed for the next day in the bureau in each patient's room. This plan saves time in the morning. Linen for emergencies is left in the locked linen closet on each floor so that it is available to nurses.

We have found that it pays to make an actual check at definite times on the student nurse who is giving out the linen; on special nurses, who are inclined to ask for more than they need, and on the regular duty nurses, who sometimes hoard linen on a floor. Teaching nurses the cost of the whole procedure of providing linen also has proved valuable.*

*Excerpts from a paper given at the meeting of the Colorado Hospital Association, 1937.

# Dietary Control in Calculous Disease

C. C. HIGGINS, M.D.

CERTAIN clinical observations lead one to infer that a definite relationship exists between the formation of urinary calculi and inadequate amounts of certain elements in the diet. This relationship has been noted by McCarrison[1] in India and Fujimaki[2] in China, as well as by other workers in various parts of the world.

McCarrison has observed in India that stone areas (regions where calculi are unusually prevalent) occur in localities where the people exist on poorly balanced diets, and Joly[3] found also that in England stone areas occur in Derbyshire and in Westmorland.

In this country, it has been observed that such areas are to be found in southern Florida and southern California with a question of one along the border of New Mexico. Doctor Noble[4] in Siam reports that the greatest incidence of calculi occurred in the poorer classes who lived in the agricultural districts and they occurred most frequently in the first ten years of life. He states, "there is no doubt that the children who suffer from stones have had diets deficient in vitamin A."

A few years ago, letters were sent to various urologists in different countries in an effort to elicit definite information regarding stone areas. From their replies, it was observed that stone areas exist in India, China, Egypt, Palestine, the east coast of England, Dalmatia, Siam and the valley of the Volga in Russia.

When these regions are studied carefully, it is apparent that there is a definite deficiency in the diet of the inhabitants in all of these regions. Vitamin A is usually present in inadequate amounts and in general the diet is poorly balanced.

Still more striking is the observation that, in certain countries, a marked decrease in the incidence of calculous disease in children has occurred in the last century. This is especially true in England and France, and Joly[3] states that in those countries in which progress regarding knowledge of nutrition has occurred, the incidence of calculous disease in children has diminished.

In 1934, we began a series of experiments at Cleveland Clinic in which white rats were maintained on a diet deficient in vitamin A for 250 days.[5] Postmortem study revealed the presence of vesical calculi in 88 per cent and of renal calculi in 42 per cent of the experimental animals. These calculi were composed of calcium phosphates and carbonates which was to be expected since the reaction of the urine shifted to the alkaline side when the animals were receiving inadequate amounts of vitamin A and thus the stones were composed of salts that are precipitated in an alkaline urine.

Later, uric acid calculi were produced in chickens; stones composed of alkaline salts were produced in a similar manner in dogs.[6] It was demonstrated also that renal and bladder stones which were too large to be expelled spontaneously, as shown by roentgen examination, would undergo dissolution and disappear when vitamin A was restored to the animal.

Further work demonstrated that the chemical constituents of the stones could be changed by further alteration of the diet. At this time a criticism was expressed that there was no evidence to indicate that the people of this country were not receiving adequate amounts of vitamin A in the diet. This criticism, however, has been adequately refuted. The Ohio State Experimental Station has shown that the vitamin A content of milk during the

## DIETARY RULES IN TREATING URINARY CALCULI

**1. Close cooperation between the patient and physician is not only important but essential in the dietary management of urinary lithiasis.**

**2. Hospitalization to establish a satisfactory diet for each individual is advised to facilitate closer cooperation between the dietetic department and the physician.**

**3. Careful determination of the *p*H of the urine from each kidney is necessary before the high vitamin A acid or alkaline-ash diet is prescribed.**

**4. Frequent biophotometer tests are necessary to ascertain that the patient is utilizing adequate amounts of vitamin A.**

[1]McCarrison, R.: Experimental Production of Stone in Bladder, Brit.M.J. **1:**717-718 (April 16) 1927.

[2]Fujimaki, Y.: Formation of Urinary and Bile Duct Calculi in Animals Fed on Experimental Rations; Note on Treatment, Japan M. World **6:**29-35 (Feb.) 1926.

[3]Joly, J. Swift: Stone and Calculous Disease of the Urinary Organs, St. Louis, C. V. Mosby Co., 1931.

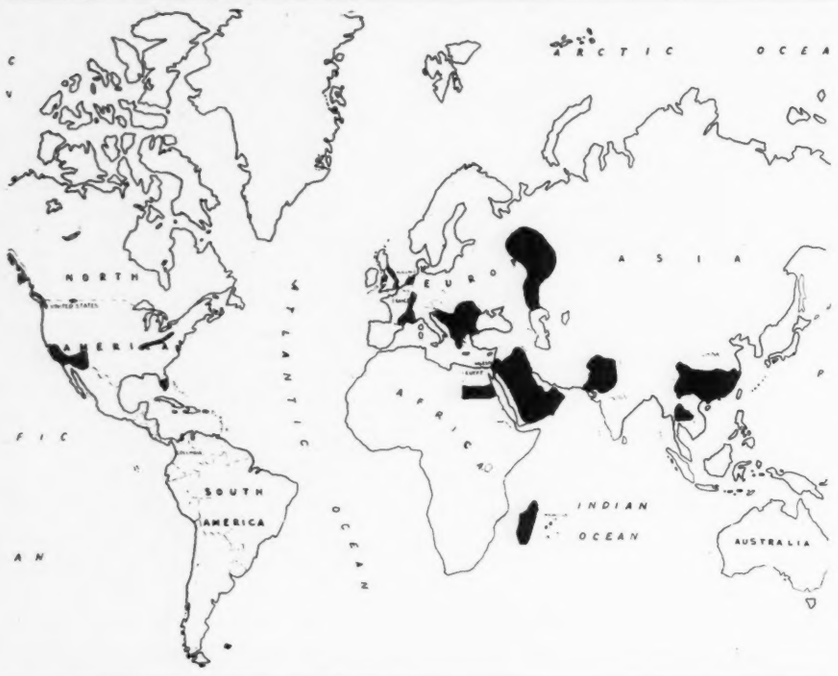
[4]Noble, cited by Addison, O. L.: Urology in Children, Proc.Roy.Soc.Med. **29:**1295-1306 (Aug.) 1936.

[5]Higgins, C. C.: Experimental Production of Urinary Calculi, J.Urol. **29:**157-170 (Feb.) 1933.

Experimental Production of Urinary Calculi in Rats, Urol.&Cutan.Rev. **38:**33-39 (Jan.) 1934.

Production and Solution of Urinary Calculi; Experimental and Clinical Studies, J.A.M.A. **104:**1296-1299 (April 13) 1935.

[6]Higgins, Further Observations on the Experimental Production of Urinary Calculi, Trans.Am.Ass.Genito-Urinary Surgeons, 157-162, 1935.



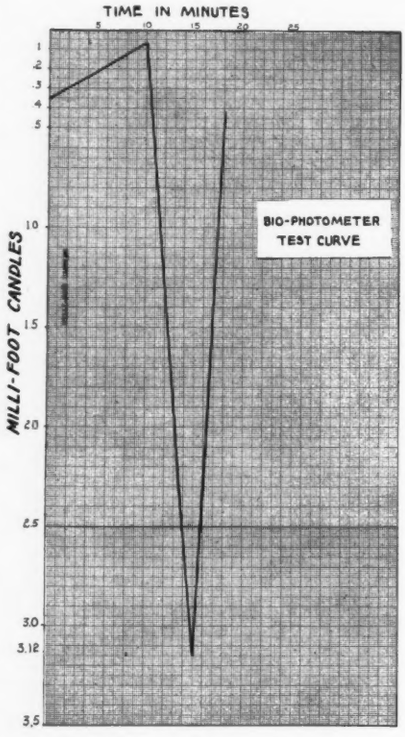

**Map of the world on which the black areas indicate the "stone" regions, which exist in India, China, Egypt, Palestine, Siam, England and Russia.**

winter months may be one-half of that in the summer months when the cows are grazing in the pastures.

It has also been demonstrated that the vitamin A content of eggs toward the end of the laying season may be only one-half that of the summer months. Therefore, our chief sources of vitamin A, *i.e.* milk, cream, butter and eggs, vary considerably during the year and this fact must be taken into consideration in computing the intake of this substance.

Further proof of deficiency in vitamin A came with the development of the biophotometer test. Jeghers[7] recently states, "More important, however, was the demonstration of the frequency of the clinically detectable vitamin A deficiency." He studied a group of 162 students attending Boston University school of medicine and found that approximately 35 revealed photometric evidence of vitamin A deficiency while 12 showed clinical evidence. He also noted that the factors responsible for producing the deficiency had been present for months and in some instances, for years.

Youmans, in discussing Jeghers' paper, stated that in using a similar photometer he found subnormal dark adaptation in one-half of 50 clinic patients, the diets of many of whom were thought to be inadequate. A similar observation was made in 11 of 54 supposedly normal subjects whose diets appeared to be as well-balanced as the average.




**Biophotometer test curve that demonstrates a vitamin A deficiency in a patient with renal calculi.**

Jeans[8] in 1936 utilized the biophotometer test for detecting vitamin A deficiency in children. In a study of 100 children of middle and low economic levels in a rural community, he observed that 26 per cent had a positive test of vitamin A deficiency. Of 102 children of all economic levels in a village, 53 per cent presented similar evidences. Of 70 children of upper economic levels in a city, 56 per cent gave a positive test of deficiency.

In a study of 70 children of middle economic levels in the city, 63 per cent gave a positive test and of 62 children of low economic level in the city, a positive curve of vitamin A deficiency was observed in 79 per cent. Of 78 village and city children who had a positive test of vitamin A deficiency and to whom adequate amounts of vitamin A were administered, all but three developed a normal adaptation to darkness after a period of vitamin A therapy.

Dr. W. J. Ezickson and Dr. J. B. Feldman[9] in 1937, by employing the dark adaptation or light sensitization test found that in 25 patients with urolithiasis, 24 gave a pathologic dark adaptation varying from a mild to a severe degree. At the Cleveland Clinic, from 68 to 79 per cent of the patients with urolithiasis gave a positive test of vitamin A deficiency as revealed by the biophotometer test.

All these reports definitely establish the fact that varying degrees of vitamin A deficiency are present among the American people. The biophotometer test is the most reliable method of determining vitamin A deficiency and it should be included as a part of the routine examination of all patients with calculous disease. A patient's history of his diet is not a trustworthy indication because of the many variable factors which always must be considered.

In considering the diet to be prescribed for a patient with calculous disease it must be remembered that individualization is essential and hospitalization is preferable, close cooperation between the dietetic and

[7]Jeghers, H.: Degree and Prevalence of Vitamin A Deficiency in Adults, J.A.M.A. **109:**756-761 (Sept. 4) 1937.

[8]Jeans, P. C. and Zentmire, Z.: The Prevalence of Vitamin A Deficiency Among Iowa Children, J.A.M.A. **106:**996-997 (Mar. 21) 1936.

[9]Ezickson, W. J. and Feldman, J. B.: Signs of Vitamin A Deficiency in the Eye Correlated With Urinary Lithiasis, J.A.M.A. **109:** 1706-1710 (Nov. 20) 1937.

clinical departments being of the utmost importance. The amount of proteins, fats and carbohydrates in the diet each day is varied until the *p*H of the urine is maintained at the correct level. Therefore, two diets are utilized: first, the vitamin A acid-ash diet and second, the high vitamin A alkaline-ash diet.

The high vitamin A acid-ash diet is used when the *p*H of the urine from the kidney containing the calculus is alkaline in reaction. The purpose of the diet is to shift the *p*H of the urine to the acid side at a point at which precipitation of phosphates and carbonates (alkaline salts) does not occur and at the same time not to reduce the *p*H far enough to the acid side to have precipitation of uric acid and urates.

The high vitamin A alkaline-ash diet is prescribed when the *p*H of the urine from the kidney containing the calculus is strongly acid in reaction. Again the *p*H of the urine is shifted toward the alkaline side to a point at which the uric acid and urates are not precipitated and likewise the phosphates and carbonates are maintained in complete solution.

From these considerations it is obvious that the diet will be efficacious in the prevention of recurrent formation of calculi following operative removal of a renal calculus, the type of diet to be prescribed depending upon the *p*H of the kidney urine and the chemical constituents of the calculus that has been removed by surgical intervention.

Not infrequently, patients are encountered who at varying intervals of time pass small stones spontaneously. Dietary control in this group gives most gratifying results and the formation of further calculi is prevented. Again the type of diet to be advocated depends upon the *p*H of the kidney urine. A chemical determination of the constituents of one of the calculi that has been passed previously is highly desirable.

The diet is also of value in preventing the formation of calculi in patients with orthopedic problems while they are required to rest in the recumbent position for long periods of time. The vast majority of the calculi in such patients is composed of phosphates and carbonates. Therefore, the acid-ash diet is prescribed and the *p*H of the urine is checked at frequent intervals, preferably every second day, to be certain the *p*H is maintained at the desired level. The value of this diet in the prevention of calculus formation in orthopedic patients has recently been stressed by McCague.[10]

Since most renal calculi produce obstruction, it is imperative that patients for whom conservative dietary treatment is contemplated be selected carefully. If the calculus is producing an obstruction or if a coexisting urea splitting infection is present, operative removal of the calculus is advisable followed by the institution of dietary management. When statistics show the incidence of recurrences to be from 9 to 51 per cent following the surgical removal of a renal calculus, the importance of a carefully planned postoperative routine is obvious.

There are reports of cases in which the high vitamin A acid or alkaline-ash diet has been used in patients with a renal calculus that was producing an obstruction. In addition an urea splitting infection has been present and an intravenous urogram has revealed stasis.

I wish to warn against prescribing dietary treatment in this group of patients in an attempt to cause complete solution of the calculus. As the stone is producing obstruction, it is necessarily destroying renal parenchyma; therefore, conservative treatment is contraindicated. Furthermore, due to the presence of stasis and the type of infection, the *p*H of the urine cannot be controlled. Thus dietary management in this group should only be instituted as a procedure following operative removal of the calculus.

In another group of patients, a small calculus is present in the kidney but is not producing an obstruction. In these patients, infection can be eradicated and the *p*H of the urine controlled. In such cases it is justifiable to advocate conservative dietary treatment if it is strictly supervised. In a collected group of more than 40 cases in which calculi too large to pass spontaneously were present, such stones have undergone solution following dietetic management. The majority of this group revealed a *p*H on the alkaline side and the sediment of the urine contained phosphates and carbonates.

More than 79 patients who passed stones at frequent intervals have been relieved of symptoms over a period of three years. The incidence of recurrent formation of renal calculi following operative removal of a stone has been reduced from 16.9 per cent to 4.7 per cent by the addition of the high vitamin A acid or alkaline-ash diet to other therapeutic procedures employed in the past.

[10]McCague, E. J.: Personal Communication.

# Fires in Grease Ducts

PRECAUTIONS, if carefully observed, that will materially reduce the danger of fires in grease ducts in hospital kitchens, are contained in a recent bulletin of the National Board of Fire Underwriters. Any duct leading from cooking equipment is likely to collect combustible material in the form of grease and lint. If considerable cooking is done the duct will become coated in a short time with thick deposits of grease, the bulletin states. Because of heat and draft these deposits are easily ignited.

The board recommends that "ducts should be at least 18 inches from any unprotected combustible material." They become a fire hazard if they extend through combustible walls, partitions or floors; when this is necessary the board specifies installation of ventilating thimbles.

To prevent accumulation of deposits and to facilitate cleaning, ducts should be as straight as possible. Frequent cleaning of the duct is imperative and doors for this purpose should be placed at intervals. Steaming is an effective method of removing grease. Washing with a noninflammable grease solvent also is satisfactory, but expensive, unless the system is small. Filters may be placed at the inlet to the duct to collect grease and when used should be cleaned at least every few days.

When ducts are in continuous use, cleaning by burning is satisfactory if they have been so installed that they do not constitute a fire hazard and if the fire department is notified beforehand.

Hand extinguishers of the carbon dioxide type or the vaporizing type, if the system is small and the top can be reached easily, are recommended when fires do occur.

# How new Extractor yields

# Orange Juice *with more Vitamin C*

**GETS MORE JUICE PER FRUIT...CUTS EXTRACTING TIME**

ESPECIALLY important to hospitals is this new improvement in orange juice extraction.

By this means the vitamin C content of this foremost dietary source of the anti-scorbutic factor is increased as much as 12% to 23%.

A greater volume of juice is obtained from a given orange also. Extracting time is shortened, facilitating the service of really fresh orange juice at peak hours.

**GAINED BY OSCILLATING STRAINER**

The improvement is an oscillating strainer, incorporated in the new model Sunkist Extractor. Forced vigorously through a series of slots and holes, the juice is enriched with edible portions of the fruit heretofore discarded.

Repeated analyses show that virtually all of the vitamin C contained in the edible portion of the orange goes into the juice—from 12% to 23% more than with other methods such as pressure squeezing.

**RICH OUTER JUICE SACS REACHED**

Vitamin C is found in highest concentration toward the periphery of the orange. Power reaming dislodges these outer juice sacs along with the albedo for further shredding in the oscillating strainer.

The vitamin C (water-soluble ascorbic acid) is more completely leached out into the strained juice, making available the near-maximum of this important therapeutic food essential.

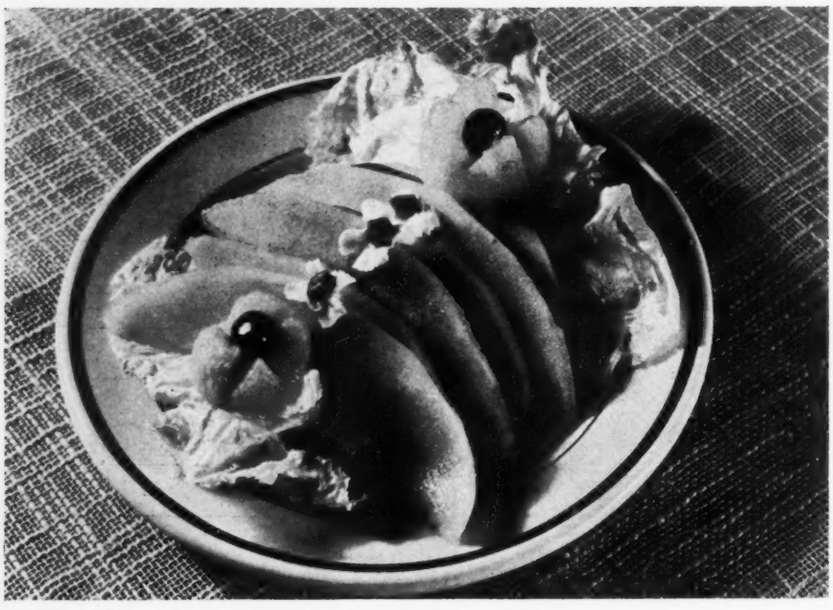

Investigate the ability of the new Sunkist Extractor to give more and richer juice from oranges in less time. It is priced at only $54.95, f. o. b., Chicago. Ask your supply house for a demonstration, or write California Fruit Growers Exchange, Sunkist Building, Los Angeles.

**Sunkist**

# Cool and Appetizing Drinks

A nourishing and cooling drink is the orange egg milk shake (right). Below is orange float, made by topping a glass of orange juice with a large spoonful of orange sherbet.

# Marinated Melon Salad



Melon
Cream Cheese
Rubyettes
Green Pepper

On a bed of lettuce place several slices of melon (cantaloupe, honeydew, Persian) which previously have been marinated in French dressing four to six hours and placed in a refrigerator to chill. All melons that are cut and without flavor or under-ripe may be used in this salad. Garnish both ends of salad at center with a Parisienne ball of melon criscrossed in the shape of a flower and insert a rubyette for effect. Serve with a lemon French dressing.—*Arnold Shircliffe, Chicago.*

## FOOD FOR THOUGHT

• A laboratory kitchen has just released some timely suggestions for cooling beverages which may be helpful to the dietitian. If fresh fruit is to be used, chill the fruit and then extract the juice just before serving time, rather than chilling the juice after extraction, which usually causes a loss of flavor if exposed to the air too long. Orange juice may be made festive by the addition of a spoonful of orange sherbet and a garnish of mint leaves.

**Orange Egg Milk Shake**
*Two Servings*

1 cup orange juice
1 cup milk
1 whole egg, slightly beaten
1 tablespoon sugar
1 teaspoon shredded orange peel

Combine ingredients and beat or shake thoroughly. Add ice to chill.

Honey is recommended for use in sweetening lemonade.

• E. F. Hopkins of the U. S. Department of Agriculture's laboratory at Laurel, Miss., has reported a faster method for dehydrating fleshy vegetables. Processes now being used for this purpose are expensive, as it takes considerable fuel to force the water out of the living cells and the high degree of heat necessary sometimes damages the tissues.

Under the new process vegetables are treated with a gas or vapor of some fat-dissolving substances, such as chloroform, sulphur dioxide or carbon tetrachloride, after they have been reduced to a pulp. This hastens the process by killing the cells quickly, thus permitting the liquid contents to seep out. It is then much easier to evaporate the water and drive off the poisonous gas at the same time.

Mr. Hopkins warns, however, against "wide claims for the dehydration of vegetables for food use," because of the fact that many of the soluble food elements, such as vitamins, mineral salts and flavors, ooze out of the cells with the water.

• The Cincinnati chapter of the American Dietetic Association has been pushing recipes for quantity work. Recently plans were made for a food parade meeting, at which each member would bring one dish as an example. The recipes were sent in and mimeographed, so that copies were available for distribution at this meeting. Sixty-seven food samples appeared in the food parade and later formed a buffet luncheon. All recipes were tested and found absolutely dependable. This sounds like an excellent way of arousing interest in the collection of large quantity recipes.

# September Dinner Menus for the Small Hospital

Doris Lister
Dietitian, Sunny Slope Sanatorium, Ottumwa, Iowa

| Day | Soup or Appetizer | Meat | Potatoes or Substitute | Vegetable | Salad or Relish | Dessert |
|---|---|---|---|---|---|---|
| 1. | | Steak, Gravy | Mashed Potatoes | Frozen Peas | Combination Salad Bowl | Green Apple Pie |
| 2. | | Catfish, With Lemon | Parsley-Buttered Potatoes | Grilled Tomato | Celery and Olives | Sliced Peaches and Cream, Brownies |
| 3. | | Baked Ham | Escalloped Potatoes | Frozen Spinach | Mustard Pickle | Pineapple Upside-Down Cake, Whipped Cream |
| 4. | | Fried Chicken, Milk Gravy | Candied Sweets | Cauliflower | Sweet Relish | Watermelon and Cantaloupe Balls |
| 5. | | Swiss Steak With Spanish Sauce | Pilau | String Beans | Sliced Cucumbers in Vinegar | Lady Baltimore Cake |
| 6. | Scotch Broth | Liver and Bacon | French Fried Potatoes | Creamed Onions | Lettuce, French Dressing | Roly-Poly, Fruit Sauce |
| 7. | | Pot Roast | Navy Beans | Frozen Spinach | Emergency Relish | Toasted Coconut Pudding |
| 8. | | Pork Chops | Escalloped Potatoes | Beets | Fresh Applesauce | Gingerbread, Whipped Cream |
| 9. | | Cold Salmon With Tartare Sauce | Mashed Potatoes | Fried Eggplant | Sliced Tomato | Lemon Pie |
| 10. | Jellied Consommé | Meat Balls and Spaghetti With Rye Bread | | Cut String Beans | Raw Vegetable Salad, French Dressing | Half Cantaloupe |
| 11. | | Roast Lamb, Gravy | Browned Potatoes | Frozen Asparagus | Currant Jelly | Angel Cake, Peppermint Whipped Cream |
| 12. | | Country Cured Fried Ham | Hominy | Grilled Tomato | Celery and Olives | Pineapple Tapioca |
| 13. | Chilled Fruit Juice | Veal Cutlets | Parsley-Buttered Potatoes | Creamed Carrots | Green Pepper Sticks | Gold Cake |
| 14. | | Corned Beef | Delmonico Potatoes | Cabbage | Mustard Pickle | Lime Ice |
| 15. | | Prime Ribs of Beef | Franconia Potatoes | Whole String Beans | Horse-Radish Sauce | Floating Island |
| 16. | Bouillon | Haddock With Lemon | Persillade Potatoes | Frozen Spinach | Pickled Beets | Apricot Whip, Whipped Cream |
| 17. | | Braised Beef | Cubed, Pan Roasted Potatoes | Cabbage | Carrot and Green Pepper Sticks | Cherry Pie |
| 18. | | Pork Chops | Creamed Potatoes | Summer Squash | Spiced Fruit | Date Bars |
| 19. | Tomato Broth | Veal Stew With Hot Biscuits and Honey | Boiled Potatoes | Celery and Carrots | Lettuce, Parisian Dressing | Baked Custard |
| 20. | | Steak, Gravy | Mashed Potatoes | String Beans | Sliced Tomato | Half Cantaloupe |
| 21. | | Baked Ham | Candied Sweets | Peas | Grilled Pineapple Rings | Ice Cream |
| 22. | | Pot Roast | Frozen Baby Limas | Glazed Carrots | Horse-Radish Sauce | Chocolate Pie |
| 23. | | Fish With Lemon | Stuffed, Baked Potatoes | Frozen Spinach | Celery and Olives | Loganberry Pudding |
| 24. | Alphabet Soup | Spareribs | Browned Potatoes | Sauerkraut | Carrot and Green Pepper Sticks | Honeydew Melon |
| 25. | | Chicken Pie | Mashed Potatoes | Beets | Sweet Relish | Jelly Roll, Whipped Cream |
| 26. | | Lamb Chops | Parsley-Buttered Potatoes | Cauliflower | Pineapple-Mint Jelly | Pumpkin Pie, Black Walnut Topping |
| 27. | | Salisbury Steak | Creamed Potatoes | Frozen Peas | Coleslaw | Patrician Delight, Whipped Cream |
| 28. | | Roast Pork | Buttered Sweets | String Beans | Mixed Pickles | Fruit Sherbet |
| 29. | | Filet Mignon | French Fried Potatoes | Grilled Tomato | Lettuce, French Dressing | Chocolate Pudding With Cream |
| 30. | | Fish With Tartare Sauce | Mashed Potatoes | Frozen Asparagus | Molded Cranberry Salad, Mayonnaise | White Cup Cakes |

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

# Monthly News Review

Vol. 51 August 1938 No. 2

## Proposed National Health Program Will Be Beneficial to Voluntary Hospitals

A "coordinated, complete, interlocking health program for the nation," as Dr. C.-E. A. Winslow of Yale University described it, was presented to the National Health Conference which met in Washington, D. C., July 18 to 20, on the suggestion of President Roosevelt and at the invitation of Josephine Roche, chairman of the federal interdepartmental committee to coordinate health and welfare activities.

The conference was attended by more than 150 delegates and probably 200 or more "observers" representing medical, dental, hospital, nursing, social service and other professional groups and an equal representation of consumers drawn from labor, farm, youth, unemployed, parent-teacher, press, radio and similar organizations. Delegates were not expected to speak for their organizations and no formal action was taken.

Five principal recommendations were laid before the conference:

1. Expansion of existing cooperative federal-state programs of public health and maternal and child health services.

2. Expansion of general hospital facilities in rural areas and general, mental and tuberculosis facilities in urban areas where present provisions are inadequate, through use of federal and state aid to needy localities.

3. Federal grants-in-aid to the states to provide better service to those on relief and those slightly above the relief level. This program would utilize voluntary and proprietary hospitals, if of good standards, as well as government hospitals.

4. A comprehensive program of general medical service for all who need it provided either as government aided health insurance or as public medical service comparable to public education. For this, also, existing voluntary hospitals would be extensively utilized and would be paid for their services.

5. Insurance against loss of wages during sickness.

The total maximum annual cost to federal, state and local governments of recommendations 1, 2 and 3 was estimated tentatively at $850,000,000 excluding duplications. Expenditure would start on much smaller levels and not reach this total for five or ten years. The distribution of suggested expenditures was as follows:

| | *First Year* | *Maximum (10th year)* |
|---|---|---|
| Public health services. | $ 20,000,000 | $200,000,000 |
| Maternal and child health | 19,000,000 | 165,000,000 |
| General hospitals | 84,600,000 | 84,600,000 |
| Tuberculosishospitals | 21,000,000 | 21,000,000 |
| Mental hospitals | 40,300,000 | 40,300,000 |
| Diagnostic and health centers | 150,000 | 150,000 |
| Care of medically needy | 50,000,000 | 400,000,000 |
| Totals (excluding duplications) | $235,050,000 | $850,000,000 |

An insistent and powerful demand came from both A.F. of L. and C.I.O. unions and from farmers, women's clubs, general consumer groups, youth organizations, unemployed groups and other representatives of consumers that prompt and effective action be taken along the lines suggested by the technical committee.

The medical profession revealed a split, official representatives of the A.M.A. minimizing the importance of the problem and urging further delay while other physicians declared that sufficient study has already been made and action can now begin.

The A.M.A. was roundly scored on numerous occasions by public and professional representatives for failure to meet the needs.

The dangers in unnecessary delay were outlined by Dr. Thomas Parran, surgeon general, U.S. Public Health Service, who declared that "the care of the public health may well be the next great social advance in this country."

Probably all political parties will have health planks in their next national platforms, said Michael M. Davis. He urged that the liberal and the conservative groups in the medical profession "learn to work together on a democratic basis which gives adequate representation to minority groups."

A plea for caution in starting federal programs and for the conservation of voluntary effort in the health field was made by Dr. S. S. Goldwater.

(*Continued on page* 104)

## A.C.H.A. to Confer Honor on New York Commissioner at Convention in Dallas

Dr. S. S. Goldwater, New York City commissioner of hospitals, will speak at the annual dinner and convocation of the A.C.H.A. when it meets in Dallas, September 24 to 26. His subject will be "The Future of Hospital Administration."

At this time honorary fellowship in the college will be conferred on Doctor Goldwater. New fellows, members and junior members will be inducted into the organization at the convocation exercises. Fellowship also will be accorded to those members whose advancement has been recommended by the board of regents at the convocation, which will be on Sunday evening, September 25.

The general session of the college, which is open to all administrators, will be held on Monday morning. Dr. Claude W. Munger will present his paper on the educational content of the administrative internships and comments and discussion from the floor will be encouraged.

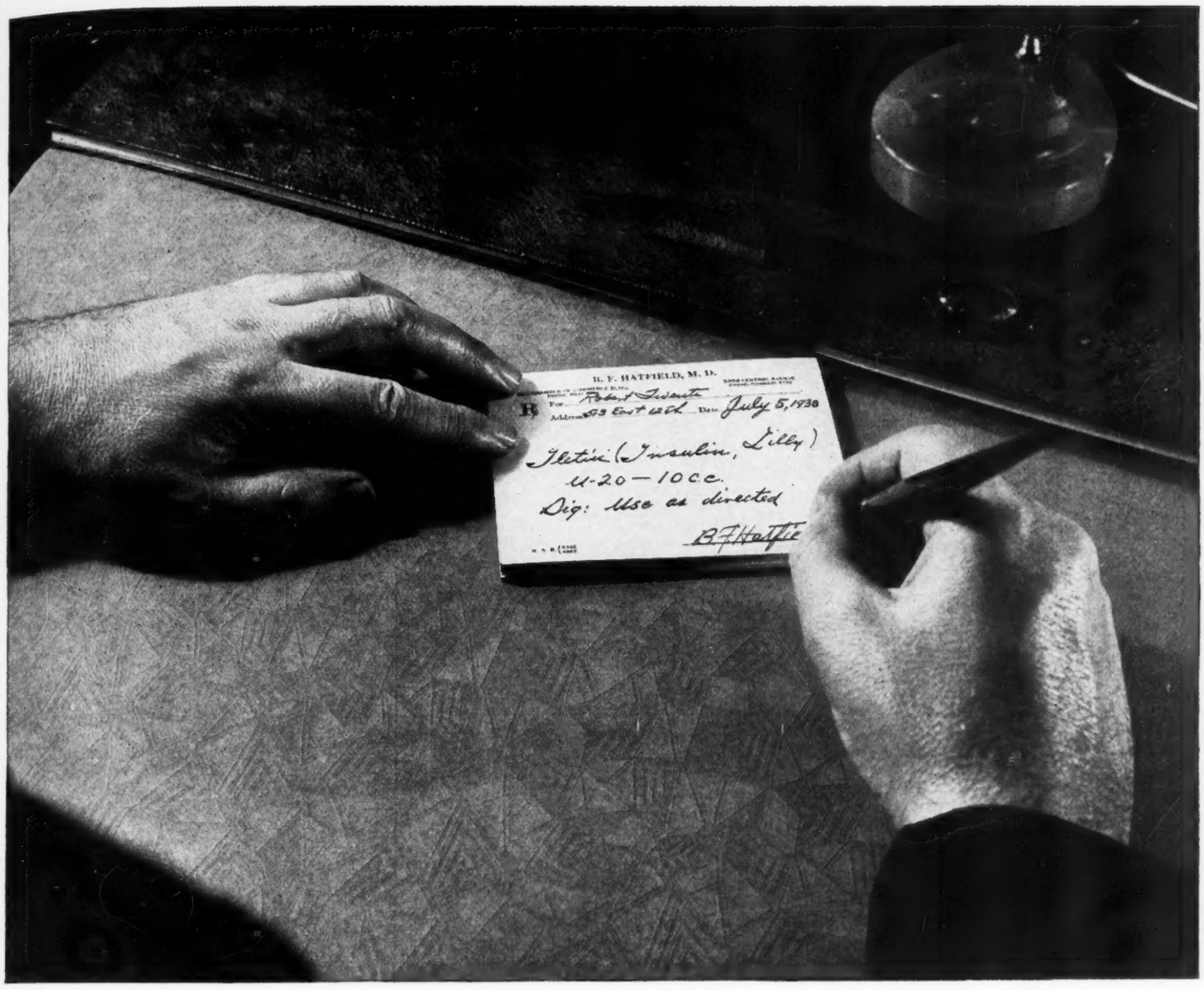
The contemplated survey service for small institutions, the possibility of establishing a life or salary allotment insurance plan for the college membership and the extension of the educational and institute programs of the college will be primary considerations of the executive committee when it meets Sunday morning.

### Miss Anscombe Improving

E. Muriel Anscombe, administrator of the Jewish Hospital of St. Louis and a member of the editorial board of The Modern Hospital, is becoming steadily better but is still far from well, according to reports from her physician. Miss Anscombe suffered a stroke on May 11.

### Therapists Select Chicago

The American Congress of Physical Therapy and the American Occupational Therapy Association will hold joint sessions, September 12 to 15, at the Palmer House, Chicago. Preceding these sessions, the congress will conduct an intensive instruction seminar in physical therapy for physicians and technicians, September 7 to 10.




**ELI LILLY AND COMPANY** has reason to be glad that the doctor's memory is long, that his judgment is based on results, that his confidence in therapeutic agents depends on fact and not on hearsay. Between the medical profession and Eli Lilly and Company there exists a bond of respect that is the natural outgrowth of long years of close association.

Physicians look with favor upon prescription stocks featuring Lilly Products, including:

*Iletin (Insulin, Lilly)*—The first Insulin commercially available in the United States.

*Protamine, Zinc & Iletin (Insulin, Lilly)*—Developed in co-operation with Dr. H. C. Hagedorn, of Copenhagen, Denmark, and the University of Toronto.

## ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

# Protestant Hospitals to Open Three Day Meet With "Association Night" Program

The American Protestant Hospital Association will open its Dallas meeting on September 23 with an "association night" program when it convenes for a three day meeting preceding the convention of the A.H.A.

The address of welcome will be given by Dr. J. H. Groseclose of the Methodist Hospital of Dallas. President Clinton F. Smith will give a résumé of the year's work and President Elect Bryce L. Twitty will present ideas for the forthcoming year. Bishop Smith of Dallas, who will be the principal speaker at the opening session, will talk on "The Protestant Hospital and Its Purpose."

The Saturday morning session will open with a short period of meditation, followed by three papers: "The Protestant Denomination and Its Hospitals" by Dr. N. E. Davis; "The Protestant Hospital and Methods of Its Constituency" by Asa S. Bacon, and "Unique Characteristics of a Church Hospital" by Dr. John G. Martin. These papers will be summarized by Frank J. Walter. A round table session on problems of a church hospital will be conducted by Robert Jolly and Arthur M. Calvin.

Saturday noon there will be a luncheon on the Peacock Terrace of the Baker Hotel.

Saturday afternoon the same general program will be followed. Two important papers will deal with "Training the Clergy in the Art of Visiting the Sick" by Dr. Henry Hedden and "Unsuspected Possibilities in Our Membership" by Albert G. Hahn and T. J. McGinty. The subsequent round table session on public relations will be conducted by Alden B. Mills and R. E. Heerman.

At the annual banquet on Saturday evening the attorney general of Texas, William McCraw, will give the principal address. President Robert E. Neff of the A.H.A., Dr. Malcolm T. MacEachern of the American College of Surgeons and President Howard Bishop of the A.C.H.A. will each discuss the relation of his organization to the A.P.H.A.

"Spiritualizing Our Social Contacts" will be the theme of the Sunday morning session for women members conducted by Mrs. Hahn and Mrs. Smith preceding Sunday morning worship in the Dallas churches. Speakers from the association will appear in many Dallas churches.

## Coming Meetings

**Western Institute for Hospital Administrators.**
Next meeting, Stanford University, Calif., Aug. 8-19.

**National Hospital Association.**
Next meeting, Hampton, Va., Aug. 14-16.

**University of Chicago Institute for Hospital Administrators.**
Next meeting, Chicago, Sept. 7-17.

**American Congress of Physical Therapy and American Occupational Therapy Association.**
Joint sessions, Palmer House, Chicago, Sept. 12-15.

**American Hospital Association.**
Annual convention, Dallas, Tex., Sept. 26-30.

**American Protestant Hospital Association.**
Next meeting, Dallas, Tex., Sept. 23-25.

**American Dietetic Association.**
Next meeting, Milwaukee, Oct. 9-14.

**Missouri State Nurses' Association.**
Next meeting, Kirksville, Oct. 17-19.

**Association of Record Librarians of North America.**
Tenth Annual Conference, New York, Oct. 17-21.

**American College of Surgeons.**
Next meeting, New York, Oct. 17-21.

**Ontario Hospital Association.**
Next meeting, Toronto, Oct. 19-21.

**American Public Health Association.**
67th Annual Meeting, Kansas City, Mo., Oct. 25-28.

**Kansas Hospital Association.**
Next meeting, Pratt, Oct. 29.

**National Stewardship Convention.**
Next meeting, Hotel Stevens, Chicago, Nov. 1-3.

**Symposium on Mental Health of American Association for the Advancement of Science.**
Next meeting, Richmond, Va., Dec. 28-30.

## New York Exempts City Nurses From Three Year Residence Law

A vigorous drive for the enrollment of qualified graduate nurses residing in New York will be made during the coming fall by the department of hospitals, Dr. S. S. Goldwater, commissioner, has announced.

Recently the department of hospitals was forced to seek exemption of city hospital nurses from the residence law which requires that all city employes shall have been New York residents for at least three years. The immediate observance of this law would have necessitated the closing of at least three of the city's general hospitals, Doctor Goldwater said.

New York City annually requires about 1500 replacements of graduate nurses to keep its city hospitals staffed in accordance with the terms of the eight hour nursing law. The city hospitals were exempted from the residence law for a two year period by a resolution approved by the council.

## Nation's Leading Hospital Administrators Will Advise at Convention Conferences

A new departure on the program of the fortieth annual convention of the A.H.A. in Dallas, Tex., September 26 to 30, will be the availability of nationally known hospital administrators who will each morning discuss hospital problems with individual or small groups of superintendents having similar problems.

Important current subjects such as the practice of medicine and the hospital, hospital care insurance, hospital privileges and obligations, governments and hospitals and labor relations will be presented on the convention program.

The trustees' section will be on Tuesday evening of the convention week and the trustees' conference on Wednesday morning. These sessions will be under direction of hospital trustees.

## Hospital Officials Asked to Stewardship Meeting

Hospital administrators, trustees and chairmen of finance committees have been invited to participate in a sectional meeting devoted to financial needs and problems of hospitals at the National Stewardship Convention at the Hotel Stevens in Chicago, November 1 to 3.

The convention is only one part of the National Stewardship Movement, a program being sponsored in the interest of privately supported philanthropies through the Golden Rule Foundation. It aims to promote an increase in the present average of giving from approximately 2 cents of every dollar toward the 15 per cent of net income exempted from income taxes if contributed to religious, educational or welfare work.

### Plan Model Medical Unit

The six wing hospital building to be started this fall for crippled children at "Nemours," estate of the late Alfred I duPont, near Wilmington, Del., will be one of the most complete medical units in the country, with every facility from a scientific museum, research laboratories and therapeutic swimming pools, to an auditorium built so beds can be wheeled into it. Plans for the million dollar hospital have been announced by Dr. A. R. Shands, superintendent and medical director of the Nemours Foundation.

# BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

## VI. COOLING THE TIN CONTAINER AFTER THERMAL PROCESSING

● On this page we have previously described certain basic operations in commercial canning procedures. These have included cleansing of the raw material; blanching; exhausting or pre-heating; sealing the tin container; and thermal processing of the sealed container. In this—the last of this series—we shall discuss the final basic operation, namely, the cooling of the sealed can immediately after the heat process.

One main reason for rapid and thorough cooling of the can contents—as soon as the objective of the heat treatment has been fulfilled—is more or less self-evident. Prompt cooling checks the action of the heat and thus prevents undue softening in texture or change in color of the food. Also important, particularly in the case of foods of an acid nature, is the prevention of excessive chemical action between the food and the metal container, which may occur if the contents of the can remain hot for an extended period of time. In modern practice, two types of cooling are commonly used, namely, air cooling and water cooling.

Air cooling, as the name implies, involves cooling of the tin container by facilitating radiation of its heat into the air. This type of cooling is adaptable to certain products in small cans. In other products, or in the case of larger cans, it is employed chiefly when the slower loss of heat, characteristic of this cooling method, is essential either for preservation of the food, or for the production of certain quality characteristics in the final product. Modern air cooling is accomplished in well ventilated, specially designed warehouses where the cans are piled in rows, allowing ample space between rows for efficient air circulation.

The several methods of water cooling and the technique by which they are carried out are detailed elsewhere (1). Briefly, water cooling may be effected in a variety of ways. The hot cans may be cooled by admitting water into the retort in which they were processed, or they may be cooled after removal from the retort by conveying the cans through tanks of cold, running water or through cold water showers. Large size, or irregularly shaped cans—processed under steam pressure—must be cooled in the closed retort at the end of the process to avoid undue strain on the containers. This is accomplished by "pressure cooling" in which pressure is maintained in the retort during the cooling of the cans, to counterbalance the pressure which develops during the process within the can itself. Commercially, cans are water-cooled to about 100°F. so that enough residual heat remains to dry the can exterior.

Present day canners are fully aware of the importance of cooling their products rapidly and completely as soon as the process is completed, in order to insure the production of canned foods with high quality characteristics. Consequently, in modern canneries the cooling operations are strictly supervised like the other basic operations in the commercial canning procedure. After inspection and labeling, the cooled cans are then ready to enter distribution channels for delivery to the consumer.

In this series of six discussions, we have attempted not only to describe the basic steps in commercial canning procedures, but also to explain their purposes. We trust this series may help bring a better understanding of this important method of food preservation.


**AMERICAN CAN COMPANY**

**230 Park Avenue, New York, N. Y.**


(1) 1936. A Complete Course in Canning, 6th Ed. The Canning Trade, Baltimore.

*This is the thirty-ninth in a series of monthly articles, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research. We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.*


**The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.**

# Anesthetists Will Find a Full Program Awaiting Them at Convention in Dallas

Convention headquarters for the sixth annual meeting of the National Association of Nurse Anesthetists being held September 26 to 30 in conjunction with the A.H.A. convention will be at the Hilton Hotel, Dallas. General sessions will be in Daugherty Hall at Fairpark Auditorium, which is about two miles from the hotel.

The opening day will be devoted to the meetings of the board of trustees and special committees. The program will begin officially on Tuesday with an address of welcome by Mayor George A. Sprague of Dallas and greetings from President Robert E. Neff of the A.H.A.

Different types of anesthesia and their ministration will be discussed at the general session on Tuesday afternoon. Speakers who will appear on this program include Dr. L. E. Williford of Houston, Tex., who will discuss "Sodium Amytal and Ether in Thyroidectomies"; Sister Mary Clementine, St. Mary's Hospital, Galveston, Tex., "My Experience in the Administration of 10,000 Anesthetics"; Dorothy Lee, Houston Clinic, Houston, "Helium — Its Value in Therapeutics and Anesthesia"; Dr. Howard DuPuy, Baylor University Hospital, Dallas, "Watching the Condition of the Spinal Anesthesia Patient During Operation," and Dr. W. H. Potts, Dallas, "Oxygen Therapy."

A banquet will follow that evening at the Dallas Athletic Club at which Laurence Melton of Dallas will be guest speaker.

Participants in the Wednesday morning session will include Anne Beddow, Norwood Hospital, Birmingham, Ala.; Virginia C. Godbey, Norfolk General Hospital, Norfolk, Va.; Gertrude L. Fife, University Hospitals, Cleveland; Alice M. Hunt, Yale University School of Medicine, New Haven, Conn.; Louise G. Halford, Meharry College Hospital, Nashville, Tenn.; Osa M. Beck, San Angelo Medical and Surgical Clinic, San Angelo, Tex. Hazel J. Peterson, Fairview Hospital, Minneapolis, will preside.

At noon the alumnae association of the University Hospitals of Cleveland will have Hilda R. Salomon of the Jewish Hospital, Philadelphia, as guest speaker at a luncheon at the Hotel Hilton.

Alice Barth of Youngstown Hospital, Youngstown, Ohio, will preside at the Wednesday afternoon session, which will feature the following physicians and anesthetists on its program: Dr. C. B. Carter, St. Paul's Hospital, Dallas; Dr. John V. Goode, Dallas; Olive Berger, Johns Hopkins Hospital, Baltimore; Kathleen Sturgeon, University Hospital, Ann Arbor, Mich.; Dr. G. Herbert Beavers, Methodist Hospital, Fort Worth, Tex.; Ione Wessinger, Henry Ford Hospital, Detroit; Dr. C. F. Clayton and Grace Richardson of St. Joseph's Hospital, Fort Worth; Dr. Azro T. Woods, Dallas Medical and Surgical Clinic.

Rose G. Donovan of Mount Sinai Hospital, Philadelphia, will preside at the Thursday morning session, which will open with a panel discussion on "Relation of the Anesthetist to the Hospital and the Surgeon" by Dr. Charles W. Flynn of Dallas and Bryce L. Twitty, superintendent, Baylor University Hospital, Dallas. Hattie Vickers of Vanderbilt University Hospital, Nashville, Tenn., and Frances Hess, Long Island College Hospital, Brooklyn, N. Y., will participate in a discussion, "Training of the Nurse Anesthetist."

Thursday afternoon will be given to a business session and on Friday morning, September 30, a clinic will be conducted at Baylor University Hospital by Dr. James T. Mills.

### Baltimore Plan Makes Rapid Strides

During a period of seven months Baltimore's nonprofit Hospital Service Plan has enrolled more than 21,000 members. This rapid growth of an average of 3000 new subscribers a month is the third fastest growing plan in the country, being exceeded only by New York City and Rochester, N. Y. More than 275 business establishments in Baltimore have made the Hospital Service Plan available to their employes.

### Receives Second Grant

The Commonwealth Fund of New York has awarded a second grant to the University of Chicago for the continuation of the graduate course in hospital administration until Oct. 1, 1939. The funds of this grant will be used for the purposes of aiding worthy students by scholarships for residence work, meeting the instructional expenses involved and providing for the preparation of teaching materials.

## *Young Patients' Interest in Radio Brings Broadcast to Bedsides at Montefiore*

Special preparations of some sort were afoot at Montefiore Hospital for Chronic Diseases, New York. A special stage, 20 by 35 feet, rubber matting on the floor and special lighting were being installed in an improvised auditorium.

The occasion was a special broadcast on July 12 of a popular children's radio program. The Columbia Playhouse was moved temporarily to Montefiore Hospital so that more than 70 child patients and 630 adults could see the performance.

Nila Mack, whose popular children's program, "Let's Pretend," stars the young Mauch twins, learned of the young patients' interests in these broadcasts from Dr. E. M. Bluestone, director of the hospital, and offered to give a broadcast from the hospital.

The production staff included the usual engineers, sound men and producers necessary to a broadcast, and a full orchestra in addition to the cast. Montefiore fortunately was equipped for radio, which facilitated the work of the sponsor and her staff.

## Philadelphia Hospital Merger Begins Construction Program

Medical and hospital facilities of the University of Pennsylvania will be substantially increased under a program of development announced by Thomas S. Gates, president. Included in the project is $1,000,000 worth of new construction.

Legal recording of the merger between the University Hospital and the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases on July 1 formally launched the program.

Orthopedic and neurologic work of the university will be coordinated with the famous institution it absorbs.

New buildings include two rebuilding projects and construction of a new hospital unit.

### Western Meeting to Seattle

The Association of Western Hospitals has selected Seattle, Wash., as the meeting place for its 1939 annual convention and has designated the Olympic Hotel as the convention headquarters. The tentative date for the convention will be the week of May 22.

## Chicago Hospital Institute Will Continue to Emphasize Demonstration Type Session

The program for the sixth annual institute for hospital administrators at the University of Chicago, September 7 to 17, will continue to emphasize the demonstration type of session found successful in previous institutes, in which the department heads of the hospital conduct a demonstration under the direction of the hospital administrator.

As in former years, the institute will be sponsored by the American Hospital Association and the American College of Hospital Administrators, with the cooperation of the American College of Surgeons, the American Medical Association, the Chicago Hospital Council and the University of Chicago.

Morning sessions will consist of lectures by prominent hospital administrators and other hospital personnel. The afternoons will be devoted to demonstrations at eighteen Chicago and suburban hospitals. Evening programs will be given over to round table discussions led by Dr. Malcolm T. MacEachern.

### Authorities Will Speak

Official greetings to delegates will be extended by Robert E. Neff, president of the A.H.A. Other prominent hospital authorities who will appear on the program are: Frank J. Walter, superintendent, St. Luke's Hospital, Denver; Leonard Shaw, assistant secretary, A.H.A.; Dr. Neal N. Wood, field director, Study on Medical Care Required and Available in Cook County, Illinois; William H. Spencer, dean, University of Chicago School of Business; Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, and editor of The MODERN HOSPITAL; Dr. M. Edward Davis, attending obstetrician and gynecologist, University of Chicago Clinics; Kate Daum, Ph.D., director, department of nutrition, University of Iowa Hospitals; Helen Branham, R.N., superintendent, North Mississippi Community Hospital, Tupelo; M. H. Eichenlaub, superintendent, Western Pennsylvania Hospital, Pittsburgh; Mary B. Miller, R.N., superintendent, Presbyterian Hospital, Pittsburgh, and Dr. G. Harvey Agnew, president elect of the A. H. A.

A Western Institute for Hospital Administrators, which will be held at Stanford University from August 8 to 19, will pattern its program after the plan devised for the University of Chicago institute.

### Society for Blood Transfusion

Transfusionists and hematologists in this country are being invited to form a national committee being organized as a part of an International Society for Blood Transfusions and Hematology now under consideration. The purpose of this organization is to contribute to the advancement of scientific and practical knowledge concerning blood transfusion and blood studies by bringing together from the different countries those interested in these subjects. The next international congress, to be every three years, will be held in 1940 in a city not yet selected. Dr. Lester J. Unger, 135 East Seventy-Fourth Street, New York, is secretary *pro tem* of the organization committee.

## Michigan Group Contemplates Joining Tri-State Assembly

The question of joining with Indiana, Illinois and Wisconsin for its annual convention was discussed by the Michigan Hospital Association at its annual meeting in Marquette, June 23 to 24, and referred to the trustees of the association for action.

The meeting attracted a registration of 122 delegates. Convening jointly were the state associations of dietitians, record librarians and anesthetists.

Officers elected by the association are: Ralph M. Hueston, president; Mrs. Kate J. Hard, first vice president; Dr. John Gorrell, second vice president; Emma B. Dickison, third vice president; Amy Beers, treasurer; Robert G. Greve, secretary, and Dr. W. L. Babcock and William Griffin, trustees.

## Mississippi Offers Liberal Hospital Care Insurance Plan

Mississippi's new nonprofit Hospital Service Corporation, sponsored by the state hospital association, is now offering for 80 cents a month in a private room, or 65 cents in a ward, twenty-four days of hospital care with benefits increasing two days each year for three consecutive years. In addition, it offers operating room service, routine laboratory service, routine medicines, emergency room, x-ray examination fees up to $10 and all other customary routine hospital service. The executive director is E. P. Marion.

Dependent members of the subscriber's family are required to pay the hospital direct one-half of the room charge per day. This is equivalent to a discount of from 65 to 80 per cent on the average hospital bill.

## Pittsburgh Hospitals Largely Financed From Private Funds

Free bed patients numbering 33,936 were treated by 16 Pittsburgh hospitals last year at a cost of $1,774,850.70. This was $1,207,415.72 more than they received from the commonwealth of Pennsylvania for such services, it was revealed in a report submitted to the Hospital Council of Allegheny County by Abraham Oseroff, director of the Montefiore Hospital and secretary of the council.

To offset the cost of free hospital service the commonwealth contributed $567,434.98 to 13 of the hospitals that receive state funds. The other three hospitals do not receive state funds and it was found necessary to make up the deficiency in state appropriations from private funds.

The $1,207,415.72, which the hospitals found necessary to supply for bed patients, plus the $311,260.98 for dispensary patients, meant that the hospitals were called upon to provide from private sources for these combined services a total of $1,518,676.70.

## Laboratory Workers Invited to Assemble in Hot Springs

Laboratory workers from private, hospital and public health laboratories are being invited to assemble this fall for discussion of the control of syphilis through laboratory methods.

The proposed meeting, under auspices of the Committee on Evaluation of Serodiagnostic Tests for Syphilis, with Surgeon General Thomas Parran, chairman, is scheduled for October 21 to 22 at Hot Springs National Park, Arkansas.

Aims and purposes of the assembly will be to consider means and methods to improve and to make more generally available the serologic tests important in syphilis control work. Tentative arrangements call for the presentation of the program in four sections.

### New Nonprofit Plans

Nonprofit hospital service plans that already have begun operating or are contemplating operation in the future are in Newark, Youngstown and Canton, Ohio; Danbury, Conn.; Lynchburg and Newport News, Va.; Augusta and Gainesville, Ga.; Denver; Kansas City; New Hampshire; Portland, Me., and Newcastle, Pa., according to the committee on hospital service of the A.H.A.

# WHERE CLEANLINESS COUNTS— COUNT ON WYANDOTTE

In hospital cleaning, there's no room for "maybe" or "perhaps." The building and equipment must be spotless. Yet economy is vital.

An increasing number of hospital superintendents find that WYANDOTTE is the answer. They use WYANDOTTE Yellow Hoop, soap builders and bleach in the laundry; WYANDOTTE Detergent for floors, walls, painted surfaces, ceilings and porcelain; and WYANDOTTE dishwashing cleaners in the kitchen. They count on WYANDOTTE Products for uniform cleaning properties and lowered cleaning costs.

If your hospital does not use WYANDOTTE Products, find out about them. A WYANDOTTE Service Representative will gladly call on you at your convenience.

**HARD WATER**

**WYANDOTTE KEEGO CLEANER**—for dishwashing by machine in even the hardest water.

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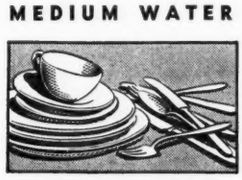
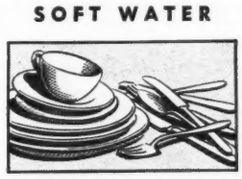


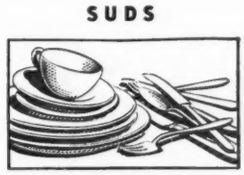
**WYANDOTTE CHEROKEE CLEANER**—for dishwashing by machine in medium hard water.

**SOFT WATER**



**WYANDOTTE CLEANER & CLEANSER**—for dishwashing by hand or machine in soft or only slightly hard water.

**SUDS**



**WYANDOTTE H-D-C**—for dishwashing by hand in either hard or soft water when a suds-making cleaner is wanted.

• Select the cleaning material that fits your water condition. Then you will get the most dishwashing with the least trouble and expense. • Water varies in different localities not only as to the amount of hardness but also the kind of hardness. • Many of those who have dishes to wash and culinary cleaning to do have solved their problems by using the WYANDOTTE Product that definitely fits their needs.

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# Names in the News

## Administrators

STANLEY FERGUSON has been appointed assistant to the director of the Chicago Lying-In Hospital and will serve as representative of DR. A. C. BACHMEYER in operating that hospital as a part of the University of Chicago Clinics. The hospital was taken over by the University of Chicago on June 1.

SURGEON WILLIAM S. BEAN, JR., will leave his post as superintendent of the U. S. Marine Hospital in Pittsburgh to head the U. S. Marine Hospital at Norfolk, Va., this month. SURGEON RALPH L. LAWRENCE of the U. S. Marine Hospital in Baltimore, will succeed Surgeon Bean at the Pittsburgh Hospital.

DR. DONALD C. SMELZER, administrator, Graduate Hospital of the University of Pennsylvania, Philadelphia, was elected president of the Philadelphia Hospital Association recently, succeeding LEWIS N. CLARK.

MARY L. NIES, R.N., superintendent of the Frederick City Hospital, Frederick, Md., has resigned. She has been superintendent of the hospital for thirty-four years.

OTIS B. BIRDSALL succeeds the late WILLIAM S. DUNCAN as superintendent of the Delray General Hospital, Detroit.

J. V. BUCK has resigned as superintendent of St. Luke's Hospital, Spokane, Wash., to become administrator of the Children's Hospital, San Francisco.

ADELAIDE F. BARTLETT has been appointed superintendent of the Homeopathic Hospital, West Chester, Pa., succeeding Margaret Faith, who resigned.

DR. FLETCHER C. STEWART has replaced DR. CLARENCE H. WARING as superintendent of the U. S. Marine Hospital at Evansville, Ind. Doctor Waring will supervise the federal prison hospital at Leavenworth, Kan.

FLORENCE B. HICKOK has resigned as superintendent of the Cohoes Hospital, Cohoes, N. Y.

DR. J. M. BEELER has resigned as superintendent of the Spartanburg General Hospital, Spartanburg, S. C., to become superintendent of Grady Hospital, Atlanta, Ga. DR. RUSSELL OPPENHEIMER, dean of Emory University Medical School, has been acting superintendent of Grady Hospital since the resignation of JOHN B. FRANKLIN several months ago.

FRANCES BISHOP, for the last three and one-half years superintendent of the Huntsville Hospital, Huntsville, Ala., has accepted a position as anesthetist and assistant to the superintendent of the Rutherford Hospital, Murfreesboro, Tenn. Her successor is VIRGINIA WELLS, who comes from the Ashtabula General Hospital, Ashtabula, Ohio. Miss Wells is a graduate of the Methodist Hospital of Memphis, Tenn.

DR. GEORGE C. STUCKY, for thirteen years superintendent of the Ingham Sanatorium, Lansing, Mich., has resigned to work on a rural health project being conducted in seven Michigan counties by the W. K. Kellogg Foundation, Battle Creek.

NAOMI ZITTROUER, R.N., has taken charge of the R. J. Taylor Memorial Hospital, which opened in Hawkinsville, Ga., a month ago.

MARGARET A. WEST, who has been superintendent of the Benjamin Stickney Cable Memorial Hospital, Ipswich, Mass., since 1935, has resigned because of ill health. Action on the resignation has been deferred by the board of trustees, who have granted Miss West a leave of absence of three months. MARY R. MCQUINN, R.N., assistant superintendent of the Faulkner Hospital, Boston, will be acting superintendent.

DR. ROY H. LONG, for sixteen years a member of the medical staff of State Hospital, Morganton, N. C., was appointed assistant superintendent recently.

ASSISTANT SURGEON ANTHONY P. RUBINO of the U. S. Public Health Service has assumed charge of the U. S. Marine Hospital at Key West, Fla., upon the departure of ASSISTANT SURGEON R. R. BRAUND.

MARY E. MARSHALL has resigned as superintendent of Dixie Hospital, Hampton, Va., after eleven years in that post. DR. H. W. KINDERMAN, retired army physician, is her successor.

DR. B. L. PAMPEL of Livingston, Mont., recently was appointed superintendent of the Montana State Hospital, Warmsprings, replacing DR. J. C. DUNN, acting superintendent since March 1937.

DR. WILLIAM F. OSSENFORT, former assistant surgeon general of the U. S. Public Health Service, has been named medical officer in charge of the U. S. narcotic hospital, now under construction at Fort Worth, Tex. The $4,000,000 institution, largest of its kind in the country, will employ 500 persons with an annual pay roll of from $600,000 to $750,000. It will have 1500 beds and is to house both narcotic addicts convicted of crime and those coming voluntarily for treatment. Doctor Ossenfort recently was in charge of the federal narcotic hospital, Lexington, Ky. Formal opening of the new hospital is scheduled for October.

ELLA J. THOMPSON, R.N., is the new superintendent of Haywood County Hospital, Waynesville, N. C., succeeding RUTH HAMPTON, R.N.

REV. SISTER ALLARD, superintendent of the Hotel Dieu de St. Joseph in Montreal, Que., received the special degree of doctor of hospital science (honoris causa) from the University of Montreal recently.

DR. J. F. KLEPFER, who has been employed at St. Mary's Hill Sanitarium in Milwaukee, is the new assistant superintendent of the Central State Hospital for the Insane at Waupun, Wis. He succeeds DR. H. R. HUNTER, resigned.

DR. RALPH E. PORTER, former head of the U. S. Marine Hospital, Fort Stanton, N. M., has been placed in charge of the U. S. Marine Hospital, Savannah, Ga., succeeding DR. JOSEPH S. BOLTON, who has been transferred to Washington, D. C.

SISTER MECHTILDA of Springfield, Ill., has been appointed new superior at St. Elizabeth's Hospital, Belleville, Ill., succeeding SISTER PETRONIA, who has retired.

DR. MALCOLM J. FARRELL, Waltham, Mass., is the new assistant superintendent of the Walter E. Fernald State School, Waverley, Mass. He has been senior physician at Metropolitan State Hospital, Waltham, Mass.

ELMA FORKNER, R.N., is the new superintendent of Memorial Hospital, Reidsville, N. C., succeeding AGNES GRAY, R.N., who resigned.

LOIS HUMBER, a member of the nursing staff at Trail-Tadanac Hospital, Trail, B. C., succeeded KATHLEEN B. HILL as superintendent when Miss Hill resigned after serving eight years in that position.

DR. ROBERT BRUCE NYE, director of the Curtis Clinic at Jefferson Medical College Hospital, Philadelphia, has been appointed medical director of the hospital, succeeding DR. HENRY K. MOHLER, recently appointed dean of the medical college.

## Department Heads

FANNY MUNROE, R.N., Edmonton, Alta., has succeeded MABEL HERSEY, who is retiring after thirty years of service as superintendent of nurses and head of the training school of Royal Victoria Hospital, Montreal, Que. Since 1927 Miss Munroe has been superintendent of nurses at the Royal Alexandra Hospital, Edmonton.

DR. ERNEST H. MCDEDE has succeeded DR. BERNARD O'CONNOR as

medical director of West Hudson Hospital, Arlington, N. J. Doctor O'Connor has been named medical director of St. Michael's Hospital, Newark, N. J.

DR. CARL JOHNSON was appointed chief of staff at the Monongalia County Hospital, Morgantown, W. Va., recently. DR. ELDON B. TUCKER was named secretary.

DR. JOHN A. SCHINDLER was elected president of the professional staff, Evangelical Deaconess Hospital, Monroe, Wis., succeeding DR. NATHAN E. BEAR.

FLORENCE BOYD, R.N., has been appointed superintendent of nurses, White Cross Hospital, Columbus, Ohio, succeeding GLADYS NICHOLS, R.N., who recently resigned to accept a position as superintendent of nurses at Ellis Hospital, Schenectady, N. Y. Miss Boyd has been assistant superintendent of nurses in the Youngstown City Hospital, Youngstown, Ohio, during the last year. She is a graduate of Cincinnati General Hospital and received an M.A. degree from Teachers College, Columbia University.

### Trustees

C. G. BOONE was reelected president of the board of directors of Allegheny Valley Hospital, Tarentum, Pa., recently.

LOUIS E. KIRSTEIN has been elected president of the board of trustees of Beth Israel Hospital, Boston. He has been chairman of the executive committee of that institution for several years.

CHARLES D. HARRINGTON was reelected president of the Harrington Memorial Hospital, Southbridge, Mass., recently for the tenth consecutive year.

HORACE B. TOBIN, for sixteen years president of the board of directors of Mercer Hospital, Trenton, N. J., has resigned. WILLIAM GUMMERE was elected his successor.

DR. F. C. LECHNER of Montoursville, Pa., has been elected president of the staff of Williamsport Hospital, Williamsport, Pa., for the coming year.

DAVID H. BRILLHART was reelected president of the board of trustees of St. Luke's Hospital, Allentown, Pa.

### Miscellaneous

HAROLD ROUSH, former credit manager of the Akron City Hospital, Akron, Ohio, has become assistant director of the Hospital Service Association of Summit County, Akron.

PETER E. KLEIN has been appointed district director of the Duluth office of the Minnesota Hospital Service Association. One of the first groups to enroll in the Duluth plan was the St. Louis County Medical Society with 100 doctor subscribers.

EVERETT E. MARTIN, a business teacher, has been appointed to the recently created position as comptroller of the North Adams Hospital, North Adams, Mass. He will undertake a complete reorganization of the hospital office and its accounting system and will supervise the accounting and the credit arrangements made upon the admission of patients.

D. LANE TYNES of Ashland, Ky., has been appointed executive director of the Community Hospital Service of Louisville, Ky.

### Deaths

JOHN H. MAUNEY, superintendent of Fort Sanders Hospital, Knoxville, Tenn., died after a serious illness of ten days with a heart affliction that had menaced him for several years. He was 53 years of age. A movement is under way to establish an oxygen room in the hospital as a memorial to Mr. Mauney. HARRY MALONEY, secretary and treasurer of the hospital, has been appointed superintendent of the institution; he has been connected with it for thirteen years.

## READER OPINION

### When to Commence

Sirs:

May I call your attention to an error in the copy of the editorial which you enclosed with your letter. In the last paragraph, you state that hospitals which wish to take advantage of P.W.A. aid must submit their applications by Sept. 30, 1938 and be prepared to start work by March 31, 1939. The public resolution passed by Congress states: "No funds appropriated under this title shall be allotted for any project which in the determination of the Administrator cannot be *commenced* prior to Jan. 1, 1939. . . ."

MICHAEL W. STRAUS
Director of Information,
Federal Emergency Administration of Public Works, Washington, D. C.

## National Health Program

(*Continued from page* 94)

Federal aid should be requested only after all possibilities of local and voluntary help have been fully explored and exhausted, he declared.

With the exception of Doctor Goldwater's caution and the open opposition of a few medical leaders such as Dr. Irvin Abell, Dr. Morris Fishbein, Dr. Olin West and Father Alphonse Schwitalla, there appeared to be substantial unanimity regarding the desirability of the ultimate objects proposed. There were, of course, many differences of opinion regarding details and some differences regarding the speed with which these objectives should be pursued.

The effect of the program will be beneficial to good voluntary hospitals, according to statements in an interview with Dr. Joseph W. Mountin and George St. John Perrott. Increased funds will be provided from which to pay voluntary hospitals for part of the cost of caring for the indigent. Additional hospitals or extensions of existing hospitals will be built only upon application of local responsible officials, approval by appropriate state officials and careful determination that existing facilities are inadequate and that new facilities can be effectively used.

Needed additions to existing voluntary hospitals probably cannot be financed by grants of government funds to these hospitals although loans could be made to them on generous terms. It was intimated, however, that the plans of voluntary hospitals needing expansion might be deeded to public bodies but the hospitals continue to be operated by nongovernment community or religious groups.

C. Rufus Rorem, director of the A.H.A. committee on hospital service, pointed out that approved plans of voluntary hospital care insurance now cover more than 2,000,000 people and will probably expand in the next few years to cover 10,000,000. He suggested that this type of service is building up valuable experience and data.

It was repeatedly stated by members of the interdepartmental committee that no attempt will be made to force a uniform program upon all states and localities and no part of the program will be federally administrated. Rather they desire local variation to meet local needs and a large assumption of responsibility by local officials. Experimentation will be welcomed. Federal funds will be used only to equalize opportunities in all parts of the country and to stimulate activity.

Hospital delegates at the conference included Edgar Blake, Gary, Ind.; Michael M. Davis, New York City; William J. Ellis, New Jersey; Dr. S. S. Goldwater, New York City; Msgr. Maurice F. Griffin, Cleveland; Felix Grisette, Chapel Hill, N. C.; Alden B. Mills, Chicago; Dr. Malcolm T. MacEachern, Chicago; Robert E. Neff, Iowa City; Dr. Ellen Potter, New Jersey; David H. McAlpine Pyle, New York City; C. Rufus Rorem, Chicago; Rev. Alphonse M. Schwitalla, St. Louis, and Frank Van Dyk, New York City.

In concluding the conference, Miss Roche declared that it had been an "overwhelming success."

# LITERATURE *in* ABSTRACT

**Conducted by E. M. Bluestone, M.D., and Joe R. Clemmons, M.D.**

## Administration of Gifts

A variable and often considerable portion of the income of voluntary hospitals is from gifts.* Donors have a right to expect that the gift will be efficiently administered in fulfillment of the objects of the institution, in accordance with the terms and restrictions (if any) imposed by the donor upon presentation.

The governing board of the institution is, collectively, in the position of trustee, or fiduciary, charged with faithful performance. A donor who considers that his gift has not been properly administered may seek a remedy in a court of equity if the gift is limited to or coupled with a specific purpose. In cases of legal differences each party to the contract has a remedy at common law if the other party fails to perform its part of the contract, provided that the aggrieved party has performed its own part of the agreement.

The management of the institution is not obligated to accept a gift if the restrictions imposed by a prospective donor appear to conflict with the aims or policies of the institution and if consent to a modification of terms is not obtainable. In case of a gift received through the will of a deceased person modifications can be effected only by an order of a court of competent jurisdiction.

As donors are eager to benefit the institution they usually seek advice from representatives of the institution when considering the purposes for which a gift or legacy is to be designated. In ordinary circumstances the maximum benefit will be obtained when the management is permitted by the donor to name, or at least to influence, the purpose for which the donation is to be used.

Gifts are either expendable or nonexpendable. Expendable gifts mainly relate to plant and current operations, while nonexpendable gifts constitute endowment. If no restrictions of any kind are imposed by the donor, the management may use a gift for that purpose which, in its discretion, will be of most benefit to the institution. Current fund contributions are of two kinds: restricted as to use and unrestricted. The responsibility of the management with respect to restricted expendable funds is to disburse the donated money strictly in accordance with the wishes of the donor. Income from unrestricted funds is wholly unrestricted as to use.

A donor may stipulate that allocation of a gift or bequest remain in abeyance for a period of years during which the management shall give consideration to the ultimate purpose for which the gift is to be used. Such a stipulation by a donor constitutes a restriction for the time being and the gift or bequest should be treated as a special fund in the meantime.

Funds which have been received without restrictions of any kind and which have not been allocated to either endowment, plant or current funds may be designated as "unrestricted funds functioning as endowment." This term should not be confused with endowment proper. Income from such funds is wholly unrestricted as to the uses to which it may be placed.

Many donors desire to honor in perpetuity the memory of one or more persons when making a gift to an institution. Although it is usual in such cases to create an endowment fund it is not necessary or desirable to place this restriction on the gift. Perpetual memory of the names involved can be suitably arranged even if the gift is wholly unrestricted.

Endowment funds are permanent and nonexpendable. Endowment funds assets should not be expended for plant or used for current operations. It is unwise to advance or lend such assets even temporarily for such purposes. Endowment funds should remain invested and intact; the income from investments should be used in accordance with the terms imposed by the donors. Income from unrestricted endowment funds assets may be used for any institutional purpose, although it is generally used to meet current operating expenses.

In formulating an investment policy, the best plan is to obtain, so far as is possible, a fair rate of return combined with safety through investment in a variety of high grade securities. It has become recognized that the securities representing investments of endowment funds and of unrestricted funds may be properly treated as one group, unless gifts are accepted with the stipulation by the donor that they must be separately invested. When securities are received as gifts, if not immediately sold, they should be set up on the books at market value at date of receipt.

One of the best aids to directors and officers of an institution in the performance of their duties and the discharge of their responsibilities is a well-designed set of accounts kept under the direction of a competent comptroller or chief accountant directly responsible to the board of directors, or to a finance committee appointed by the board through the administration of the hospital.

Periodic examinations of the accounts of institutions should be made by independent firms of certified public accountants. Systems should be reviewed from time to time and, if necessary, improved so as to make certain that all pertinent information is brought into the records and that the accounts reveal to the management and other interested persons all of the information that they may require.

*Fageant, L. W.: Gifts to Institutions, L. R. B. & M. Journal **19**:2 (March) 1938. Abstracted by Simon Tipperman.

## Rural Apprenticeships

A good internship and one year of residency are better training for a surgeon than a postgraduate course.* Nevertheless, only a few surgical residencies enable a man to do creditable surgery without further supervision. The majority of men doing surgery today have received their training and experience through assistantships and associations with older men.

The certification of surgical boards will have to include apprenticeships and assistantships in both city and rural hospitals. The kind and amount of hospital training to precede an apprenticeship should be specified and standardized and the apprenticeship shall have to be under a qualified senior surgeon.

If the group of senior surgeons is well chosen, the apprentice may receive as good or better training in private practice than does the assistant on the surgical service in the average charity hospital.

The surgeon in the rural hospital can offer the apprentice laboratory facilities, pathologic training, preoperative and postoperative care and excellent follow-up. The assistant in the rural hospital gradually increases his volume of work not only by cases turned over to him by his superior but also through his own private practice. The man training in a rural community always keeps in touch with surgical thought elsewhere.

*Snyder, Howard L., M.D.: Graduate Training From the Viewpoint of the Surgeon in the Rural Community Hospital, Bull. Am. Coll. Surgeons **23**:30, 1938. Abstracted by Arthur H. Aufses, M.D.

# BOOKS ON REVIEW

A PEDIATRICIAN IN SEARCH OF MENTAL HYGIENE. *By Bronson Crothers, M.D. New York: The Commonwealth Fund,* 1937. *Pp.* 271. $2.

A pediatrician of note offers the stimulating example of a specialist who not only is aware of the contributions which another specialty can make to his own field but also is actively attempting to bring about a *rapprochement* between the two fields, based on a realistic evaluation of the functions of both.

For the isolationists in pediatrics and psychiatry Doctor Crothers has no sympathy. He punctures the omniscient fallacies of those pediatricians who, as *"ex officio* directors of the child," attempt to deal with all aspects of pediatric medicine, physical and psychologic without having given to the mental and emotional complexities of behavior the same careful study that they consider basic to the treatment of the organic aspects of disease.

While correctly exposing the truly "regressive" character of the "psychiatry is a menace" school, the author makes it clear that he knows the limitations as well as the therapeutic possibilities of the psychiatric approach. Well-trained psychiatrists will rejoice in his astute rebuke to over-enthusiastic lay proponents of prevention, who, in selling mental hygiene to the public, have coined such baseless analogies as "mental disease is like tuberculosis." Doctor Crothers knows the difference between wishful thinking and *fait accompli.*

The author outlines a plan for inclusion of at least the rudiments of mental hygiene in the curriculums of medical schools and teaching hospitals, pointing ultimately toward intelligent cooperation between pediatrician and psychiatrist. In discussing the rôles of various ancillary workers, such as psychologists and medical and psychiatric social workers in this cooperative enterprise, Doctor Crothers has given us an analysis of working relationships that could go far toward ironing out difficulties and confusions that, unfortunately, already are acquiring the force of tradition in many hospitals and clinics.—MINNA EMCH, M.D.

PLAY AND MENTAL HEALTH. *By John Eisele Davis. New York: A. S. Barnes & Co.,* 1938. *Pp.* 202. $2.50.

The transformation in a comparatively short time of the child from an egocentric animal into a socialized being is often a disorderly and difficult process. This author propounds a general philosophy of play conducive to wholesome mental expansion, growth and development that leads to a form of socialized behavior. The book is designed primarily for practices in school and its aim is to develop a psychology of play in line with recent advances in psychic practice in child education.

The author lists certain hygienic objectives in play education and the text amply covers, through discussion and example, these objectives. The conclusions drawn indicate that play should be projected as an expansive and expressive rather than a restrictive activity and that the concept of play with each other and for each other should give a wholesome social direction to activity.

An extensive bibliography follows each chapter. A splendid contribution is made to this important subject.—B. W. BLACK, M.D.

# NEW PRODUCTS

## Needle-Point de Luxe

There just isn't any point to using a dull needle. Yet the keenest hypodermic needle must inevitably be blunted by being thrust through epidermis of varying degrees of toughness.

Recently a handy little sharpening device for the purpose of putting points on blunt needles has been introduced by Perfect Point, 2102 North Halsted Street, Chicago. By means of an easy adjustment, it is possible to give needles any desired bevel, it is stated. The sharpener will take any needle, from the smallest hypodermic to the largest special anesthesia needle. One of the features that fills the manufacturer with pride is the sharpener's simplicity of operation, which makes it possible for any nurse or orderly to operate it. The Perfect Point Company feels that its new gadget will assure a full crop of perfectly pointed needles at all times.

## Better Than Honey

"Will you walk into my light trap," said Mr. Miller to the fly. And most obligingly the fly walked in, followed by hordes of his friends and fellow citizens of the insect world. The light trap was developed originally by the Miller Company, Meriden, Conn., for use in back porches, kitchens and truck gardens where night flying insects are particularly numerous and irksome. Latterly, the use of the trap has been extended to all places where it is necessary to clear the air of insects to ensure comfort.

It consists of a globe of clear diffusing glass, having its sides pierced with three funneled slots leading to the light bulb. It comes with and without a removable bottom for dumping accumulations of dried insects. The trap is available with ceiling holder for permanent installation and also with portable attachment fitter for attaching to an ordinary light socket. Satisfactory operating results will not be guaranteed if lamps smaller than 100 watts are used.

It is said to have several advantages: (1) it is safe; (2) it works at low cost; (3) it is clean and odorless, and (4) there is no danger of electric shock. The trap serves both as light source and an insect catcher.

## Let's Shake

Bartender's arm, like housemaid's knee, is an occupational disease. But it is not necessarily confined to the boys behind the bar. Laboratory technicians, too, might easily become victims of this affliction after a hard day's work shaking up blood samples in order to count the red blood cells.

In order to eliminate this ailment as well as to save time and money, the Fisher Scientific Company, 711 Forbes Street, Pittsburgh, has bestirred itself to develop the new clinical shaker described in a recent issue of its monthly publication, "The Laboratory."

The shaker accommodates shaking platforms for hemacytometer pipettes for 12 mm. diameter test tubes. The device is said to ensure the best possible distribution of red blood cells throughout a sample because it shakes the pipettes and contents in two planes at the rate of from 275 to 285 times per minute. The motor of the shaker is air cooled.

The mechanism is enclosed in an attractive housing finished with gray and black crackle lacquer. Six pipettes can be attached to the aluminum platforms by means of rubber cups at the lower end and, at the top, by rubber cups held by spring-actuated brass plungers.

## A Roof Under Our Feet

Riding in on the annual summer crest of enthusiasm for sunshine and fresh air as cures for human ills comes the Promenade Traffic Top, a new product of the Celotex Corporation, Chicago, with which flat roofs may be converted into open air playgrounds, roof gardens and recreational areas.

The new product, applied over the roof, is said to protect the roofing from damage by traffic and rays of the sun. It is made of cane fiber impregnated with asphalt and provides a resilient, nonslippery wearing surface. It is supplied in three colors, black, green and red.

When used on hospitals, Celotex contends, waste space may be turned to good use as solariums and roof gardens.

## Painless Peeling

There is no appeal in a potato peel. Doing kitchen police, if we can believe our favorite war-story writers, was more of a trial to the high private in the rear rank than being under shellfire. One can see how that might be.

However, denuding spuds of their jackets is no longer a job to be dreaded since kindly manufacturers have invented machines to do it. A recent arrival in the ranks of potato peelers is model 6008 of the Hobart Manufacturing Company, Troy, Ohio. It has a capacity of 8 pounds of potatoes at one loading and will peel this amount in from one to three minutes and at the same time effect a saving in peel loss of from 12 to 14 per cent over hand methods. The "6008" is available in either bench or pedestal type.

## When Organ Heals Mind

Advocates of music as the premier soother of the savage breast and as an aid in mental cases are finding organ music helpful in treatment of these disorders, according to the Hammond Instrument Company, 2915 North Western Avenue, Chicago. These instruments creating musical tones from electricity are said to be capable of countless entirely original tones since the organist is able to mix his own tone colors.

The Hammond occupies a space about 4 feet square. It needs only connection with an electrical outlet to be ready to play. Its manufacturer claims that it cannot get out of tune. Working parts are constructed of materials said to be impervious to atmospheric conditions. The cost of the instrument is about that of a fine piano, and it can be moved as easily.

## New Light on Old Tasks

The alchemist of ancient times puttering about his poorly lighted den was a figure of awe and mystery to his neighbors. He was regarded as a dealer in magic—the very black variety. Probably this awesome effect was produced by the gloom with which the alchemist was surrounded, and possibly, too, the remarkable concoctions he brewed were the result of his inability to see what he was doing.

The modern magician in his up-to-date laboratory wants light and plenty of it. To supply this demand the Holophane

# From

## HOSPITAL EXHIBITORS' ASSOCIATION MEMBERSHIP 1937-38

| | |
|---|---|
| American Hospital Supply Corp. | Chicago, Ill. |
| American Laundry Machinery Co. | Cincinnati, Ohio |
| American Sterilizer Co. | Erie, Pa. |
| Angelica Jacket Co. | St. Louis, Mo. |
| James L. Angle Company | Ludington, Mich. |
| Applegate Chemical Co. | Chicago, Ill. |
| Armstrong Cork Products Co. | Lancaster, Pa. |
| B. W. Baker Linen Co. | New York City |
| Bard-Parker Co., Inc. | Danbury, Conn. |
| Becton, Dickinson & Co. | Rutherford, N. J. |
| Bruck's Nurses Outfitting Co., Inc. | New York City |
| The Burrows Company | Chicago, Ill. |
| Carolina Absorbent Cotton Co. | Charlotte, N. C. |
| Wilmot Castle Company | Rochester, N. Y. |
| Clark Linen Co. | Chicago, Ill. |
| Clay-Adams Company, Inc. | New York City |
| Warren E. Collins, Inc. | Boston, Mass. |
| Crane Company | Chicago, Ill. |
| Cutter Laboratories | Berkeley, Calif. |
| F. A. Davis Co. | Philadelphia, Pa. |
| Davis & Geck, Inc. | Brooklyn, N. Y. |
| J. A. Deknatel & Son, Inc. | Queens Village, L. I., N. Y. |
| DePuy Manufacturing Co. | Warsaw, Ind. |
| Eisele & Company | Nashville, Tenn. |
| Faichney Instrument Corp. | Watertown, N. Y. |
| Faultless Caster Co. | Evansville, Ind. |
| Finnell System, Inc. | Elkhart, Ind. |
| J. B. Ford Sales Co. | Wyandotte, Mich. |
| General Electric X-Ray Corp. | Chicago, Ill. |
| General Foods Sales Co., Inc. | New York City |
| Glasco Products Co. | Chicago, Ill. |
| Frank A. Hall & Son | New York City |
| Heidbrink Co. | Minneapolis, Minn. |
| Hilker & Bletsch Co. | St. Louis, Mo. |
| Hill-Rom Co., Inc. | Batesville, Ind. |
| Hobart Mfg. Co. | Troy, Ohio |
| Hospital Equipment Corp. | New York City |
| Hospital Management | Chicago, Ill. |
| Hospital Supply Co. | New York City |
| Hospital Topics & Buyer | Chicago, Ill. |
| Huntington Laboratories, Inc. | Huntington, Ind. |
| International Nickel Co., Inc. | New York City |
| Jamieson, Inc. | Chicago, Ill. |
| Jamison-Semple Co. | New York City |
| Jarvis & Jarvis, Inc. | Palmer, Mass. |
| Johnson & Johnson | New Brunswick, N. J. |
| H. L. Judd Co., Inc. | New York City |
| Henry L. Kaufmann & Co. | Boston, Mass. |
| Kelley-Koett Mfg. Co. | Covington, Ky. |
| Kenwood Mills | Albany, N. Y. |
| Kent Company, Inc. | Rome, N. Y. |
| Samuel Lewis Co., Inc. | New York City |
| Lewis Manufacturing Co. | Walpole, Mass. |
| Marvin-Neitzel Corp. | Troy, N. Y. |
| Massillon Rubber Co. | Massillon, Ohio |
| Meinecke & Co. | New York City |
| The Mennen Company | Newark, N. J. |
| Midland Chemical Laboratories, Inc. | Dubuque, Iowa |
| Modern Hospital Publishing Co., Inc. | Chicago, Ill. |
| Morris Supply Co. | New York City |
| National Lead Co. | New York City |
| Parke Davis & Co. | Detroit, Mich. |
| Physicians' Record Co. | Chicago, Ill. |
| Puritan Compressed Gas Corp. | Kansas City, Mo. |
| Rhoads & Company | Philadelphia, Pa. |
| Rolscreen Co. | Pella, Iowa |
| Will Ross, Inc. | Milwaukee, Wis. |
| W. B. Saunders Co. | Philadelphia, Pa. |
| Savory Appliance, Inc. | Newark, N. J. |
| Scanlan-Morris Co. | Madison, Wis. |
| F. O. Schoedinger | Columbus, Ohio |
| Schwartz Sectional System | Indianapolis, Ind. |
| Ad. Seidel & Sons | Chicago, Ill. |
| John Sexton & Co. | Chicago, Ill. |
| Sharp & Smith | St. Louis, Mo. |
| The Simmons Co. | Chicago, Ill. |
| Snow-White Garment Mfg. Co. | Milwaukee, Wis. |
| Spring Air | Holland, Mich. |
| Standard Apparel Co. | Cleveland, Ohio |
| Standard Electric Time Co. | Springfield, Mass. |
| Standard Gas Equipment | New York City |
| Standard Sanitary Mfg. Co. | Pittsburgh, Pa. |
| Stanley Supply Co. | New York City |
| Sterisol Ampoule Corp. | Long Island City, N. Y. |
| Thorner Brothers | New York City |
| Troy Laundry Machinery Corp. | New York City |
| Union Carbide Co. | New York City |
| United States Hoffman Machinery Corp. | New York City |
| Vestal Chemical Laboratories, Inc. | St. Louis, Mo. |
| Vitamin Products Co. | Milwaukee, Wis. |
| C. D. Williams & Co. | Philadelphia, Pa. |
| Williams-Pivot Sash Co. | Cleveland, Ohio |
| Wilson Rubber Co. | Canton, Ohio |
| Zimmer Manufacturing Co. | Warsaw, Ind. |

*As of April 1938*

## ONE NATIONAL ORGANIZATION TO OTHERS

*An invitation* is hereby extended to established Hospital Associations to make use of the wide and varied fund of specialized knowledge and information that is to be found in the collective experience and data of member concerns of this organization.

This association stands always ready to cooperate, through its members, in assisting other Hospital Associations to find answers to those questions with which commercial firms are more familiar. *Finances, promotion, credits, collections, legal and legislative matters—in these and many other ways Hospital Exhibitors' Association can offer you expert aid.*

We stand ready to serve.

***We invite you to submit inquiries to the Advisory Committee—a consultation body consisting of the Presidents and Secretaries of Hospital Exhibitors' Association, American Hospital Association and Catholic Hospital Association. Address care of this magazine.***

HOSPITAL EXHIBITORS' ASSOCIATION

Company, Inc., 342 Madison Avenue, New York, comes along with the Correctalite presenting the new trend, semi-direct lighting. The light controlling element consists of two parts: a prismatic reflector and a bottom bowl-shaped refractor in which there is a removable plate to permit relamping. These parts are joined into one unit by three rods which engage the bottom bowl and fasten to an annular ring in the neck of the reflector.

There are in the Correctalite, we are assured, both beauty and efficiency. Great concentration of down light on working areas with adequate ceiling illumination is said to make it admirably suited to such places as laboratories where concentrated light as well as general illumination is needed.

## Paging New Literature

**Mister Bones**—Every hospital has a skeleton in the closet, sometimes two or three. But no blackmailers need apply. These skeletons don't have to be hidden. They are, in fact, members of the hospital family in good standing and an essential part of the teaching equipment.

The Clay-Adams Company, Inc., 25 East 26th Street, New York, has been happily engaged in supplying skeletons for the closets of the medical profession for quite a while now. Not only does it supply skeletons but models and charts of practically every nook and cranny of the human anatomy.

A new catalog, entitled "Human Anatomy," contains about 130 pages of pictures, prices and information regarding Clay-Adams anatomical models; it is available to interested hospital people.

**Things and People**—The death of JAMES W. FARRELL of the Finnell System, Inc., Elkhart, Ind., occurred on June 23 after a heart attack suffered while he was on a business trip. At the time of his death he was vice president and director of sales.

In recognition of the new era of broadened social responsibility upon which American industry is now entering, the directors of Johns-Manville Corporation, New York, at the June meeting established a policy of widening the board's membership to include not merely stockholders' interests but direct representation for the viewpoint of the general public, LEWIS H. BROWN, president, announced.

To serve this purpose, the directors elected to the board one of the country's leading educators, DR. WALTER A. JESSUP, president of the Carnegie Foundation for the Advancement of Teaching.

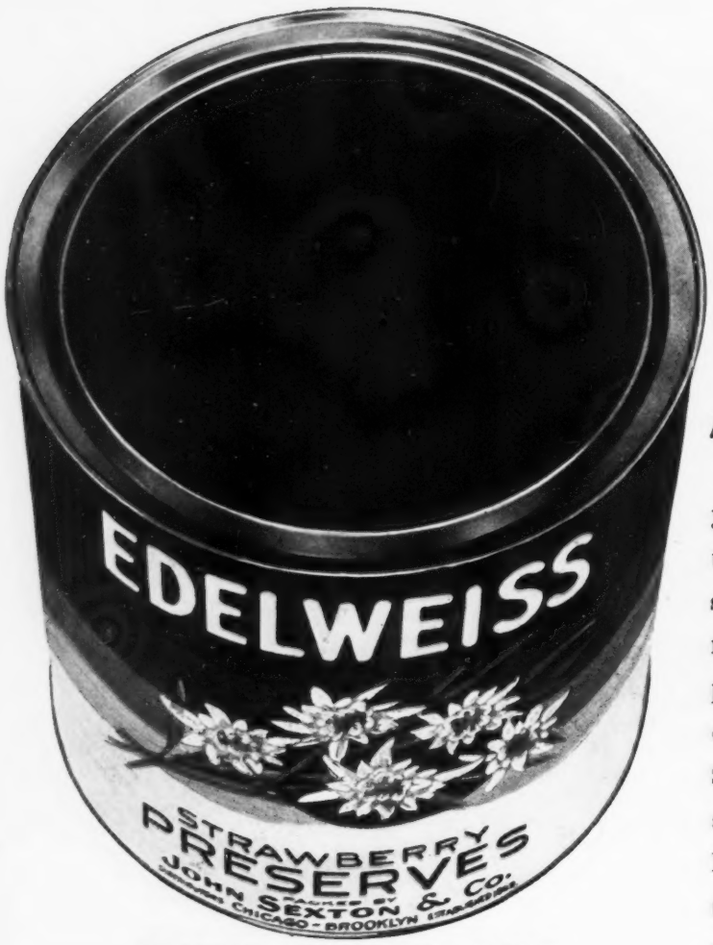
Recently, the Hobart Manufacturing Company, Troy, Ohio, honored 79 of its employes who have been in the continuous employ of the company for twenty-five years or more with a dinner and inauguration program, during which a Quarter-Century Club was organized. Highlights of history for the period covered by each class were reviewed as well as the careers of each member of the Quarter-Century Club. Certificates and diamond studded pins were presented by JOHN M. SPENCER, president and general manager of the organization.

Paging Thomas Dewey! Another racket has been eliminated according to the Westinghouse Technical Press Service. Freed from the machine-gun rattle of the rivet hammer, the 13-story Woman's Hospital of Pittsburgh has risen silently during 58 noiseless working days in the midst of the University of Pittsburgh's Medical Center. The 1000 tons of steel for Pittsburgh's first arc welded building were joined to the new Presbyterian Hospital without so much as one bang.


# the MODERN HOSPITAL

TWENTY-FIFTH ANNIVERSARY

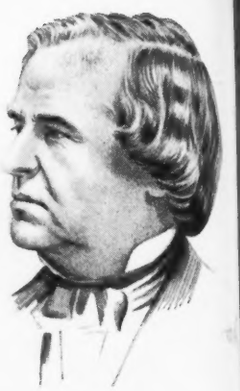
SEPTEMBER 1938




*"Let your haste marry caution. Divorce not yourself from promptness, character or quality of service to speed action, profit or seeming victory."*

**—ANDREW JOHNSON.**

*17th President of the United States*



**THE preserves, jellies and fruit butters which delighted your guests last year will be available again from Sexton this season. And you may be assured they will be equally delicious. Demanding the very finest materials, employing skilled workmen and anchoring each product to a time-honored recipe, Sexton Sunshine Kitchens produce the same high quality season after season. No effort for extra tonnage nor opportunity for profit from less expensive materials will lead Sexton to vary one iota from this fixed policy.**

## ANNUAL PRESERVE SALE

Celebrate with us, during September, our Annual Preserve Sale. Select your needs now from the pick of the new season's fruit,—cooked the Sexton way in our Sunshine Kitchens.

*Sexton Specials offer outstanding values in foods prepared exclusively for those who feed many people each day.*


## EDELWEISS TOMATO SOUP

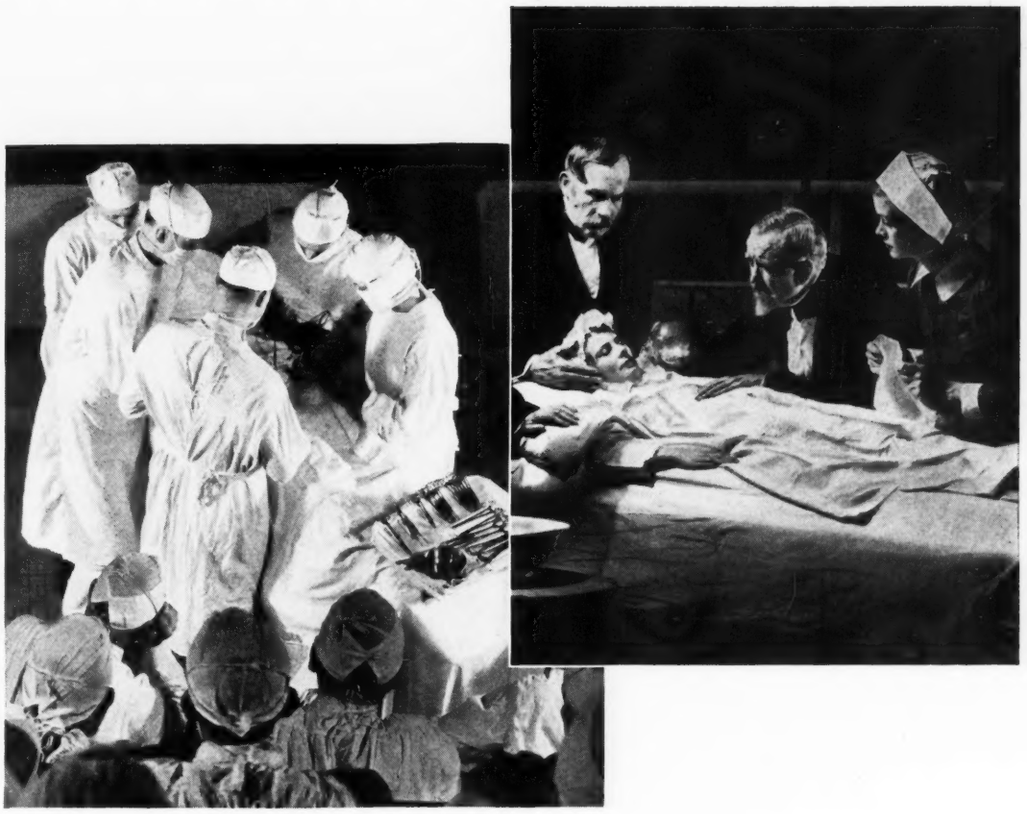
Like all Edelweiss Tomato Products, Edelweiss Soup is superlative in flavor, color and consistency. Edelweiss Tomato Soup will give you the greatest number of servings per tin.

## EDELWEISS SPAGHETTI

Whether you want macaroni, spaghetti, noodles, vermicelli, alphabets, stars, shells or any other style of alimentary paste, you will find the finest quality under the Edelweiss label in 10 and 20 pound boxes.

**JOHN SEXTON & CO., CHICAGO—BROOKLYN**

# SEXTON QUALITY FOODS



# PROGRESS

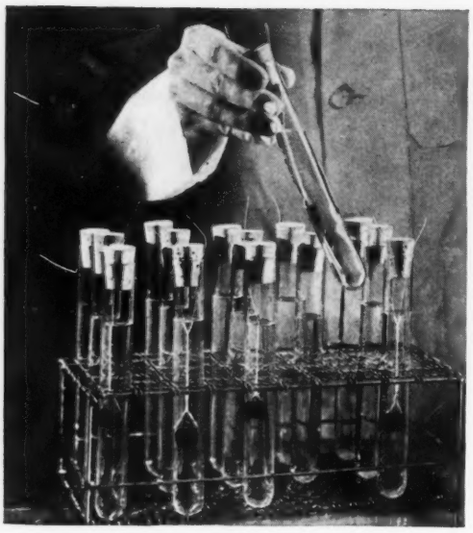
Every D&G suture has the benefit of experience accumulated during more than a quarter century of specialization in one thing.

- Experience gained in the production of over two hundred million sutures used in some thirty-five million operations.

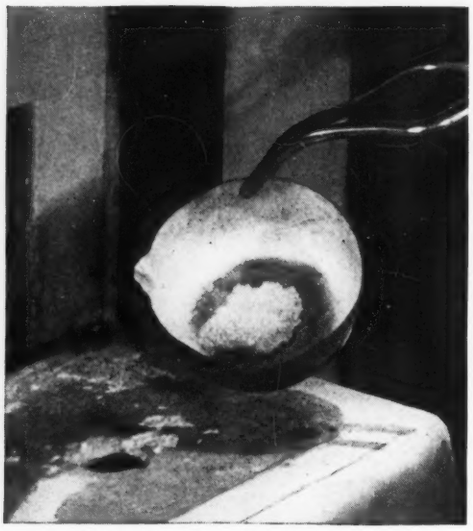
- Experience gained through a program of research begun with the inception of our business, and expanded through the years.

- Experience which has come to us through intimate association with the profession during this era of great surgical advance.

## *Davis & Geck Sutures*



Digestive tests for absorbability



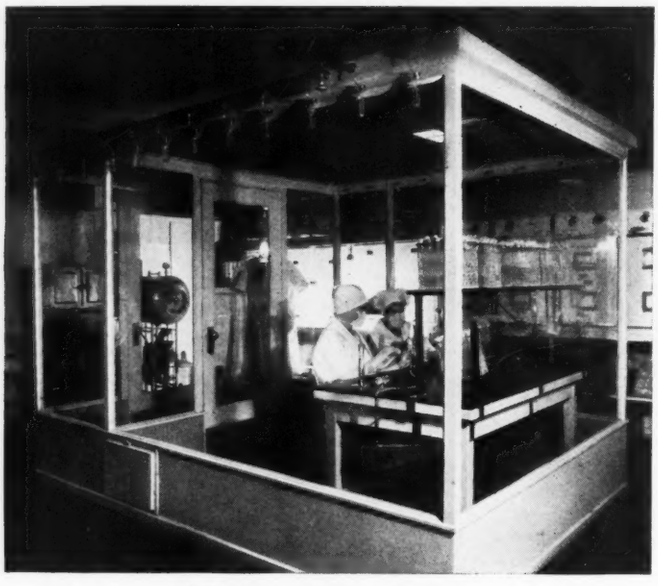
Ash analysis for chromium content

THROUGH constant development the preparation of sterile sutures has become a highly technical procedure in which rule-of-thumb methods cannot be successfully applied. If the finished product is to possess *all* the essentials of workability and proper behavior, variable factors must be considered, the chemistry of the materials must be studied, and processing regulated accordingly.

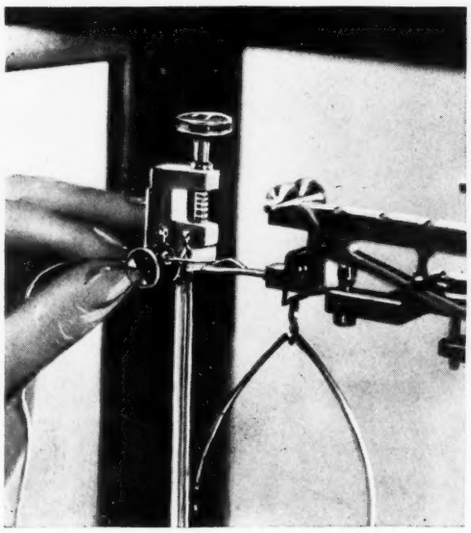
In no small degree, therefore, is the dependability and uniformity of D & G Sutures due to the thoroughness and frequency of laboratory tests throughout their preparation

*For instance:*

Before acceptance for processing, a complete chemical analysis is made of each lot of strings and tests run to



Unit of Bacteriologic Laboratory



Flexibility measured by special instruments

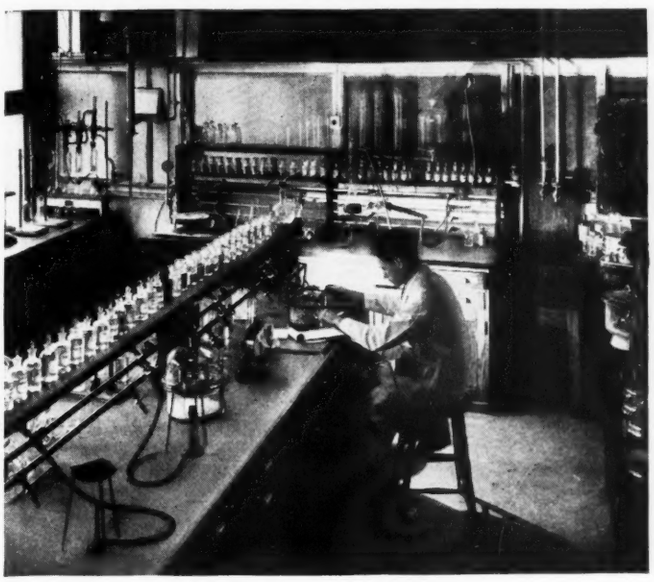
Animals for in vivo tests

determine the absence of fat, fatty acids or other deleterious substances.

Strength and elasticity are recorded with utmost exactness on specially constructed dynamometers.

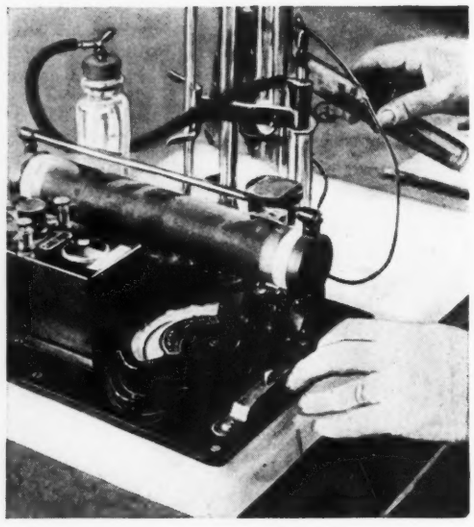
The important matter of absorbability is governed by a triple control over the chromicizing processes: *(a)* by testing the absorption rate of specimens from each lot in digestive fluids; *(b)* by ash analyses for determination of the chromium content; and *(c)* by implantation of specimens in animals.

Positive sterility is assured by the rigorous heat sterilization to which all D & G Sutures are subjected. As a further safeguard, tubes taken at random from each lot are tested aerobically and anaerobically under the most rigid bacteriologic tests.



Chemical Research Laboratory

Testing raw catgut for excess fats



Neutrality is checked by titration tests

Flexibility is accurately measured on instruments of great sensitivity.

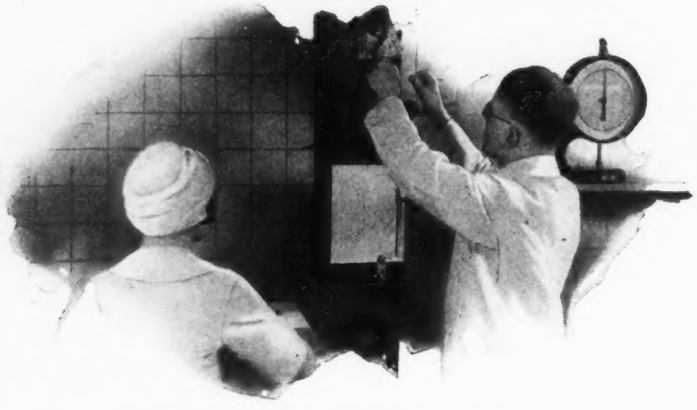
Delicate titration tests are run for verification of absolute neutrality and compatibility with the tissues.

And finally, the tensile strength tests are repeated to make sure that the finished product has retained its original integrity.

The sutures consumed in these tests and in supporting research represent a substantial percentage of the total produced.

Over a quarter of a million sutures are thus expended annually in maintenance of the high standards we have set, and in developments to meet advances in surgery.

*Davis & Geck, inc.*



Testing catgut strings for strength and elasticity

PRINTED IN THE U. S. A.

# WITH THE ROVING REPORTER
## *Twenty-Five Years Ago*

### Public Relations Then

• Quite a trip from New York to Plainfield, N. J., but a delightful excursion nevertheless, with plenty of variety, including the interesting ferry trip across the river to Jersey City and from there by train. Someone has predicted that eventually there'll be a tunnel for automobiles under the river, but it seems ridiculous on the face of it—automobiles under the water. Better perfect them first so they're safe along roads built on dry land! In the meanwhile, your Roving Reporter is perfectly happy on the ferry.

It's worth the trip to see that new private pavilion at Muhlenberg Hospital. It has 50 beds and is the latest thing in equipment. Someday it's going to be hard to tell when you wake in the morning whether you're in a hotel or a hospital. With this new three story and basement structure, Muhlenberg boasts 11 handsome buildings.

The opening was attended by effective ceremonies including a reception to "town and county officials and the medical and journalistic professions." What an intelligent board that is! By including the "journalistic profession" in its invitation, it recognizes the value of proper publicity, also how to go about getting it. In fact, one of the impressions the visitor carries away with him is the efficiency of the hospital personnel, starting with the directors who realize that a board, to govern, must be informed.

### "Official Sunshine"

• Need cheering up? If you're cheerful enough as it is, what about some of your patients?

"Official sunshine" is being dispensed in a Detroit sanitarium (name on request) by a woman who, in gratitude for her recovery after an illness of several years, is conducting a permanent "cheering-up" department. Each day she makes regular calls through the wards and dispenses great wads of sunshine to brighten the lives and raise the spirits of the shut-ins and sufferers. She already has been termed the "official sunshine" of the Detroit institution.

One patient broke down and confessed to your Roving Reporter that he was praying for a rainy day.

### A Real Report

• Not a thing is missing from that exceedingly comprehensive report just issued by the Massachusetts General Hospital. There are 333 pages in all. Incidentally, it marks the one hundredth annual report of the famous old institution.

It will do one's heart good to read over the published lists of donations,

**One of the first devices for bench work, so constructed that it could be clamped on the patient's bed.**

indicative of the apparent ease with which the hospital has been able to get funds. Page after page of reading matter is included, providing interesting sidelights on the conduct of the hospital—reports about the various general services, the out-patient department, the follow-up system, visiting nurse work, the work of the women's auxiliaries and a most entertaining account of nursing in the hospital.

Trustees in those hospitals in which the medical staff does practically no scientific work and publishes no papers would be greatly instructed by reading over the list of staff publications for the year. Exactly 104 papers have been published during the year, it appears, based on research work by various staff members in the hospital. The titles of these papers are published in the annual report, each man being given credit for the work he has done.

### Say It With Pictures

• Speaking about reports, don't fail to get the series of pamphlets that the Children's Hospital of Philadelphia is issuing to publicize the new set of buildings which are now under way. These tell most effectively the needs and the growth of the institution in pictures. Most unique are the interesting snapshots of the children now occupying the old buildings. Some of these views are even done in color and are accompanied by little historic incidents in the career of the hospital told entertainingly. Also included are vital facts and statistics.

This method of attracting intelligent notice to a most worthy philanthropy seems exceptionally good and excites speculation on the possibilities of photography in telling the hospital story.

### Interns at Charity

• One of the sights of New Orleans is the Charity Hospital. Incidentally, it was the first hospital in this country to be started by a private donation. A sailor named Jean Louis, so the story goes, gave 12,000 livres, or $2500, with which to found it. But the present story is this:

They have at Charity Hospital an intern organization that deserves attention. The hospital has 1000 beds and there are 30 interns whose services rotate through the various branches of medicine during the two years of their incumbency. Over these interns are four resident past-interns—one who has charge of medicine, one of obstetrics and gynecology and two of the surgical services. These men are chosen by competitive examination from the outgoing intern staff and each retains the place for which he is chosen during the whole year. The four men each receive $600 per year.

### As for the Future?

• Things are happening so fast and furiously these days that your Roving Reporter ponders as he pens these last lines what can be left for him to write about twenty-five years hence, that is, if he is physically able to recount what he sees and hears, provided he is able to see or hear at all.

# Looking Backward—and Forward

THE MODERN HOSPITAL is celebrating its twenty-fifth birthday. When the first issue was published the field was unorganized and the need for such a magazine was scarcely recognized.

Leaders of hospital thought, however, saw its possibilities and to them belongs the real credit for supplying hospital workers of America with their first professional publication. The advantages of private initiative were enhanced through the sustained control of editorial policies by these leaders.

Those who created this magazine declared in the first issue that "if through its efforts there shall come a higher order of service to the sick and suffering everywhere their ambitions will have been achieved."

It is for others to say what contributions The Modern Hospital has made to the betterment of hospital service during these twenty-five years.

But what of the quarter century ahead? Prophecy is hazardous but we may safely list some of the subjects calling for future discussion or solution.

1. Extension of hospital facilities where clearly needed, including more general hospitals in rural areas and additional facilities for chronic and convalescent patients in all areas.

2. Further developments in service as, for example, full exploitation of the preventive possibilities of the out-patient department; wider adoption of social service and special therapies, and integration of special services (and in many cases special hospitals) into general hospitals.

3. Enlargement of hospital standardization so that distinguished services become the rule rather than the exception.

4. Better working relations with all physicians, especially general practitioners. This involves better control of the quality of medical practice in hospitals; a just settlement of the troublous problem of financial arrangements with radiologists, pathologists, anesthetists, residents and interns, and probably compensation of physicians for out-patient work.

5. Wider education and training of all hospital people, especially administrators and department heads; adoption of modern practices in personnel management, and education of trustees in their proper functions.

6. Better public relations programs for individual hospitals and for groups of institutions including, in the latter, extension of hospital care insurance; provision from tax funds for indigents in voluntary hospitals; development of other improved methods of financing, and coordination of voluntary and government hospital effort into an effective community program.

7. Finally, improved hospital planning with effective use of new technics and materials.

To the attainment of these and similar objectives, The Modern Hospital pledges its best efforts.

Otho F. Ball

# Assignment for the

S. S. GOLDWATER, M.D.

IN A stable social order in which disturbing forces are not visibly at work, an observer might venture to peer with assurance into the near future, but these are not the conditions of today, and I am dismayed at the editor's request for an article on the "Hospital of the Future."

Twenty-five years ago I wrote an editorial for the introductory number of The MODERN HOSPITAL; I do not remember what it was about, but I hope it had to do with some current problem rather than with the future, for I am sure that I did not foresee in 1913 the problems which beset hospitals in 1938.

There is a school of biography that looks upon its subjects each as the product of his era, as an individual whose career is best explained in terms of his social environment. It is in similar terms that I think of hospitals; the hospital of tomorrow will fit the world of tomorrow. What will that world be?

Our present world is engaged in a struggle between individualism and collectivism and it is these vital forces that are now reshaping our hospitals to meet professional and social needs. Today it is the man against the mass machine, the individual doctor against the standardizing organization, the staff member against the institution, the noncooperator against the group cooperative, the private hospital against the government.

In the current struggle the voluntary hospital occupies a paradoxical position. As a unit of administration the voluntary hospital senses keenly the advantages of freedom from restraint and fights shy of official control, but apparently it has little sympathy for the medical practitioner who suspects the hospital itself of a desire to force him into a position of dependence. In theory, each voluntary hospital is ready to cooperate with others in its vicinity and class, or with its local government, in order to prevent wasteful overlapping; in practice it resents efforts to curtail its freedom of action in the name and interest of the community as a whole.

I dare not attempt to predict the ultimate effect of the prevalent conflict of ideas upon hospital organization and management; my purpose is only to examine certain aspects of today's conflict in the hospital field.

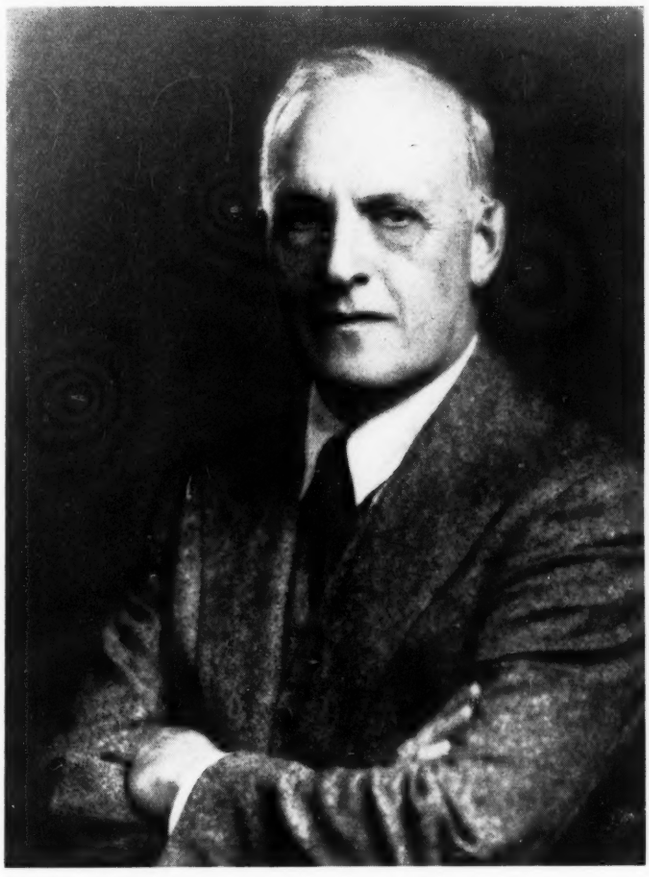
The hospital is a reflection of the need of the sick for medical care. The sick, *i.e.* individual sick persons, need diagnosis, treatment and incidental care. There arises from these needs a demand for assembling in usable form all of the known forces and weapons of modern medicine. This is a large order. Obviously, it is impossible to bring together an extensive and variously trained personnel and complete medical equipment in the private home of each patient. Therefore, communities establish hospitals where the needed experts are associated in an organization that has at its disposal laboratories, technical apparatus and instruments of precision.

When a costly hospital has been made ready for service, it is found that its elaborate resources are sufficient to meet the needs of many patients, that the distribution of the available services among a large clientele reduces individual costs, that the preservation and further development of the associated skills require constant exercise in those skills and that such exercise is possible only in connection with a variety of voluminous and well-organized clinical and laboratory services. Thus the hospital, emphatically a collective medical enterprise, seems inevitable and indispensable.

As the hospital grows, the personality of patients and doctors recedes into the background and presently complaints begin to be heard. It is said that in a large hospital or clinic the patient ceases to be regarded as a human being; that his treatment is impersonal to a disturbing degree; that idiosyncrasies are insufficiently underscored; that statistical results are overstressed; that clinical methods are routinized; that the system places too much authority in the hands of laymen and bureaucrats. The pressure of the system seems intolerable and there emerges a demand for escape from the bondage of the machine through the return

**The task I would assign to the hospital of the future is the redintegration of individual service, the achievement of the ends of medical practice within the framework of the complete hospital organization, the reconciliation of individualism and collectivism.—S. S. Goldwater.**

# Hospital of the Future



**Commissioner Goldwater, this magazine's godfather.**

and restoration to power of the old-fashioned family practitioner of blessed memory.

In the picture I have presented, the hospital stands for collective thinking and acting, for the beginning, at least, of a planned or community system of medical care; while the lamented family doctor, self-sufficient in some respects, but lacking many of the fertile and desirable resources of group practice, is the personification of individualism.

If the position of the hospital is ambiguous because its commitment to collective methods within the institution is coupled with opposition to controlled community planning, the position of the medical practitioner is equally so. Medical staffs demand that hospitals furnish all the professional and technical services that are indispensable to effective group clinical practice; hospitals comply and presently are astonished to find themselves accused by their own physicians of invading the field of medical practice.

Group medicine as practiced in hospitals, it is alleged, not only constitutes the "corporate practice of medicine" but has a tendency to depress the physician to the rank of an institutional servant. Proclaiming with passionate conviction their opposition to collective government activity in general and to state medicine in particular, state and county medical societies join their national association in declaring that "the medical care of the indigent is a state function," although the logical application of this doctrine must eventuate in the wide expansion of government hospital services and the discontinuance of private medical charity now practiced by volunteer physicians and lay contributors who jointly support nonprofit community hospitals.

To judge by the pronouncements of our most powerful medical association, organized medical activity in almost any form that involves lay or community relations is of sinister import; hospitals and clinics as commonly organized and conducted, and more especially nonprofit group hospital and medical service plans, are but the precursors of the dreaded state medicine. Medical societies, therefore, will fix all of the conditions of medical practice; will direct physicians in the conduct of both professional and public relations; will, without consultation with the consumer, decree acceptable kinds and rates of pay for medical services. Hospitals which decline to accept the terms laid down by organized medicine are to be blacklisted as unethical and woe to the independent physician who refuses to accept the rulings of the organization.

Critics of the medical hierarchy are assured that the sole purpose of the arbitrary proposals of medical organizations is to preserve the "free choice of physician," but the choice of a physician who asserts his independence of organization rule is not considered free choice in the sense in which organized medicine uses the term.

This, then is the situation: In order to progress scientifically, physicians specialize, organize clinically and form hospital staffs. To bring their service within economic reach of a large, self-supporting segment of the population whose resources are limited, they organize economically, *i.e.* make common use of scientific and technical equipment assembled for convenient use in institutions. To ensure medical service to the indigent they advocate the extension of both institutional and domiciliary government medical service; but while 99 per cent of the leaders of the profession are actively and willingly engaged in these collective pursuits, the

American Medical Association clings in theory to individualized medical practice, and in defense of its philosophy, organized medicine marches forth with banners flying, determined to cripple smoothly functioning institutions, which the profession itself has been chiefly instrumental in creating and fashioning.

The reality of the theoretical conflict between medical individualism and collectivism cannot be questioned, but it is a mistake to assume that there is a definite dividing line between the physican as the protagonist of individualism and the hospital as the advocate of collectivism. Most of the voluntary hospitals of the United States as I have come to know them are as jealous of their freedom and are as obsessed with their individuality as are the most hidebound members of the old guard of Dearborn Street.

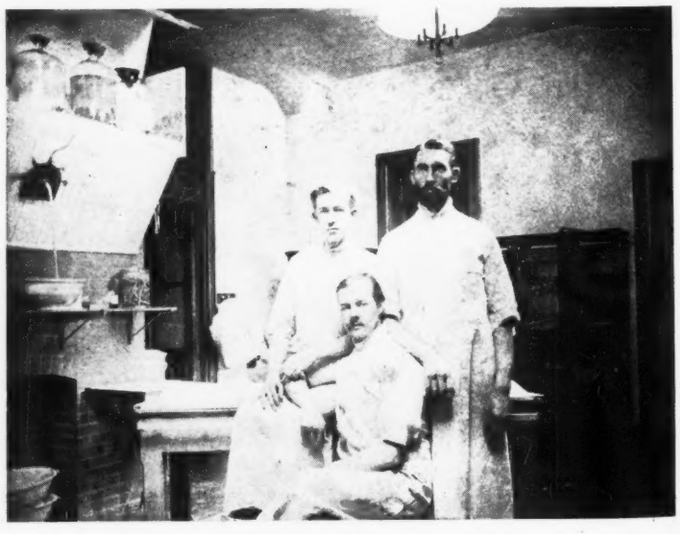
Hospitals wish to plan, struggle, advance and achieve according to the unfettered impulses of their own minds and hearts, and it is far from their intention or desire to accept set programs of action or prescribed patterns of administration. But it is undeniable that in the existing system of organized medical service there are gaps that segregated hospital units have not managed to cover. To fill these gaps is the inescapable task of hospital administration; to fill them without destroying the institutional vitality and productivity that independence alone can preserve is the purpose of the hospital administrator who is convinced of the deadening and destructive effects of regimentation.

Likewise, there are needed forms of organized medical service that the isolated private practitioner cannot supply. To satisfy these needs, the hospital type of medical organization has been created; to satisfy them without destroying the valued relationship between doctor and patient is the conscious aim of the hospital administrator who realizes that the hospital can serve, but never can replace the physician.

The principal task that I would assign to the hospital of the future is the redintegration of individual service, the achievement of the ends of private medical practice within the framework of the complete hospital organization, the reconciliation of individualism and collectivism.

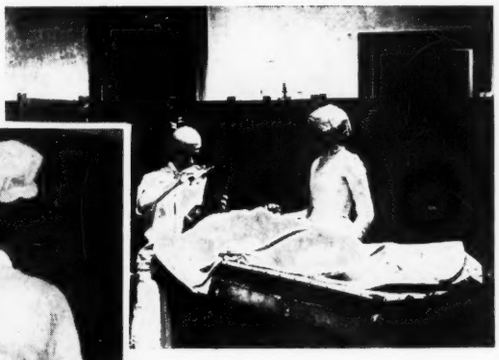

1. Hitched up and waiting for an emergency call.

4. The hospital's fashionable parlor where relatives are received.



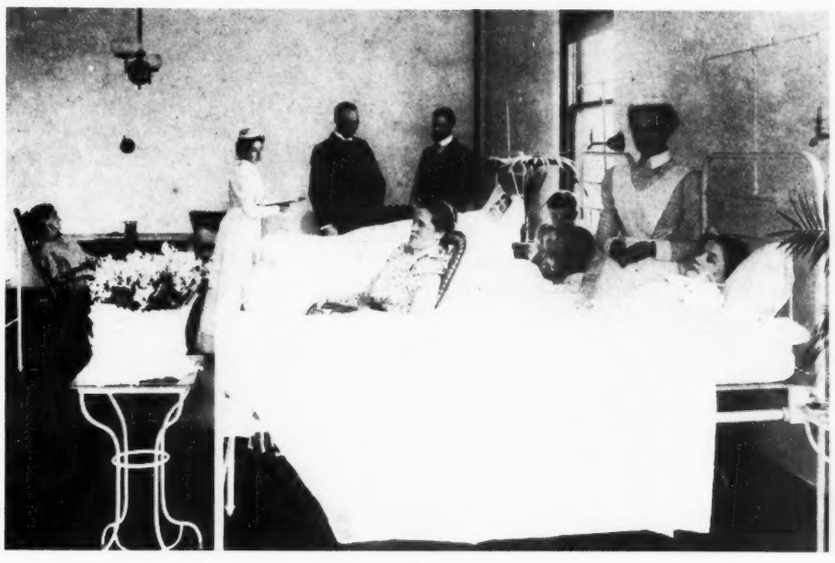
5. Solemn consultation reveals need for surgery.

# PATIENT'S PROGRESS PRIOR TO 1913



2. Patient given first aid in hospital's accident ward.

3. Nurse rushes off to "ring up" the kinfolks.



7. Several weeks of convalescence in a cheerful ward.

6. Emergency operation is decreed and is performed forthwith.

# Medical Education

TO "WALK the wards" in a great hospital with a great master of medicine was for generations the ideal method of getting a medical education. In spite of the development in recent decades of the nurses' training school, the laboratory, the x-ray and other special departments, the hospital bed still remains the essential nucleus for the training of physicians.

In a little more than a generation we have seen a striking transformation in medical education. The amount of preliminary work before admission to the medical school has been increased, the medical course itself has been lengthened, and the intern year has been accepted by a number of the medical schools and by many of the state boards as an absolutely essential part of medical training. There has also been a decided increase in the number of residencies in the various specialties.

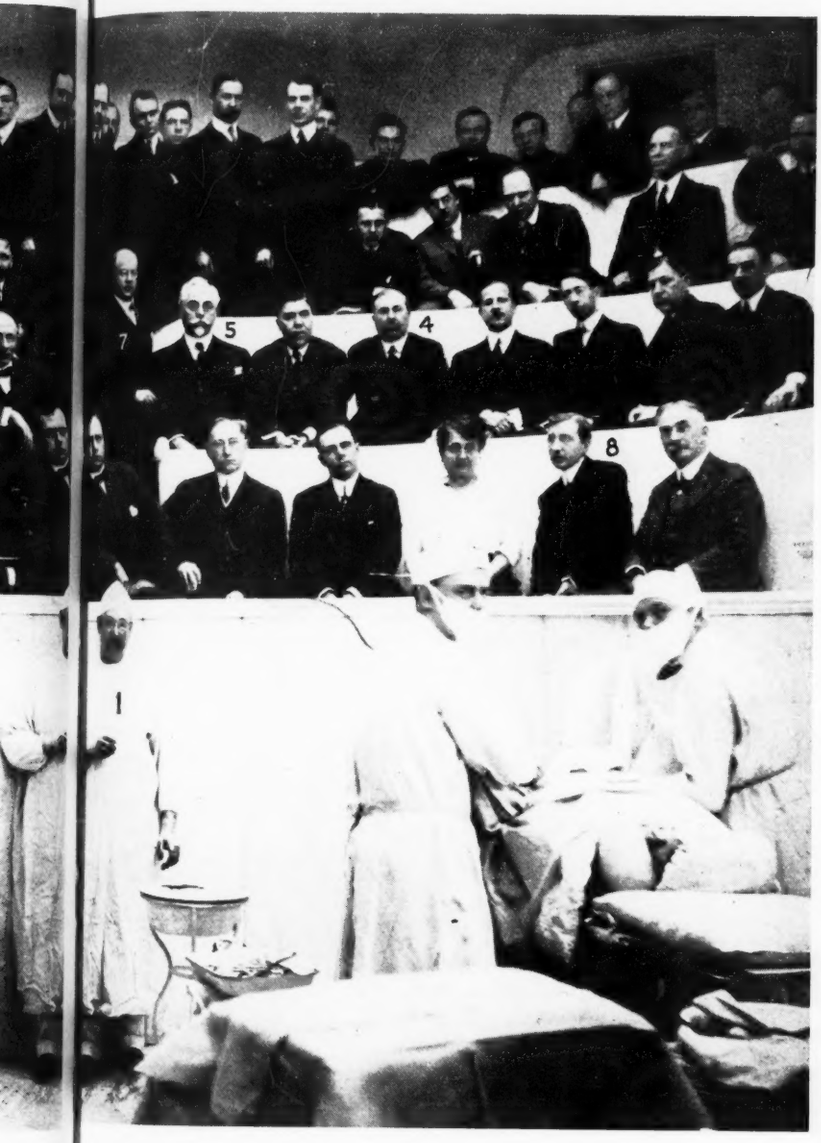
Fundamentally the hospital is a place in which the patient can readily be brought under the control of the physician with all of his helpers and with those acces-


## Will You Help to

**Gone are the frock coats of 1913. These young doctors of 1938 sit so near the field of operation that they must be masked as the surgeons are masked. Intently they incline over the chromium plated rail unconscious of camera and of all save surgeon's hands and the patient.**

# Transformed

RAY LYMAN WILBUR, M.D.




## Identify These Doctors?

**Time: 1913.**
**Place: Presbyterian Hospital, Chicago.**
**Occasion: Clinical Congress, American College of Surgeons, the third such congress in its history.**
**Surgeon: Dr. Arthur Dean Bevan (1).**
**Identified: Dr. John B. Murphy (2); Dr. A. J. Ochsner (3); Dr. A. A. MacArthur (4); Dr. Charles S. Bacon (5); Dr. Charles E. Kahlke (6); Dr. Norman Kerr (7); Dr. Paul E. Grabow (8).**

sories requisite for modern medical care. The startling increase both in the number and variety of helpers and of aids is of outstanding significance, since it is developing the hospital as the inevitable medical center for the care of the sick in the future.

For centuries the hospital was for the most part a place of residence for the sick, and almost any sort of accommodations could be and was used for hospital purposes. Now, everything about a hospital from the basement to the roof has to be planned beforehand and has to be adapted to its particular purposes. Because of the concentration of patients, of methods of care and of personnel, the hospital is the ideal spot for the training of the physician. Extensive laboratories have been brought within the hospital in many places. The ordinary four year medical course is no longer sufficient for the training of students in the fundamentals and in the technics of medical practice. Practical hospital work is required. More and more those administering hospitals have developed the rotating medical services on an educational basis. While at times the intern has been thought of more as an aid to the hospital and to the doctor, the fact that he is primarily a student and learning medicine is being thoughtfully planned for in many institutions.

The growth of the specialties in medicine has characterized the last three decades. For years the hospitals in Europe were considered desirable by many for the training of specialists, but until recently comparatively little was done in this country in graduate medical instruction. Now with the activities of the specialties boards, together with the council on medical education and hospitals of the American Medical Association, new opportunities for training in the specialties are being developed in practically all of our larger cities and in a considerable percentage of our public and large voluntary hospitals.

It seems clear that these processes now started will continue and that with more and more of those who are ill going to the hospital for care there will be constantly increasing hospital opportunities for post-graduate training. Fortunately, the more the hospital is used as an educational institution the better it is for those who come to that institution for diagnosis or for relief.

Medicine is advancing so rapidly that only the varied personnel of a large hospital can hope to keep up to date. The stimulus of the elementary as well as of the advanced student in medicine will keep our hospitals alive to all of the possibilities of medical science. Medicine moves fast, but we have shown here in America that the up-to-date hospital is able to keep abreast of it.

# Service Stripes for

RAYMOND

"MISS LUCKES was a very remarkable woman. For many years her aims were far beyond those of a rather timorous committee, timorous because every suggestion involved the spending of money which the committee did not see how to raise. But she was never discouraged at the thwarting of her ideas and wishes, nor with her failure to impress at the moment the imperative necessity of the changes she advocated. Neither bravery, nor courage, nor hope ever failed her. She felt that what she wanted was right, and should be done, and she felt that in time it would be done. . . . She lived only for the hospital, and even on her holidays she invariably took with her a shorthand writer and one of her assistants in order to make up arrears and keep pace with the work."

In such laudatory terms does Viscount Knutsford, for many years chairman of the London Hospital, pay tribute in his book, "In Black and White," to Eva Luckes who served as matron of that famous institution for forty years.

A close friend of Florence Nightingale, Miss Luckes, following her appointment in 1880, became a pioneer in nursing education and hospital organization and, with others in England and this country, paved the way for hospital care as we know it today. A true hospital woman in every sense of the word!

We have Lord Knutsford to thank for this concise characterization of hospital women. Added to his distinction as the man who raised, during a period of some thirty years, $30,000,000 for his hospital, he deserves recognition as a trustee who, even in that early period of voluntary hospital history, appreciated and was sympathetic to the problems of hospital management.

How many times since might those words have been voiced as appropriately by other hospital presidents, with a change in name only! Unfortunately few laymen have revealed the keen interest, personal devotion and rare knowledge of hospital affairs that Lord Knutsford did in England fifty years ago.

The priceless heritage bestowed by those pioneer women upon their professional sisters is responsible in

**Trim in her modern office sat this typical woman administrator of 25 years ago. "Neither bravery, nor courage, nor hope ever failed her," it is said.**

# Hospital Women

P. SLOAN

no small measure for women's part in hospital work as we have known it during the years. Surely there is no need to stress the importance of their contribution to the steady progress that has been made in the care of the sick. There are few hospitals that have not engraved on their records the self-sacrificing labors of one or more such valiant women.

The scene changes from old London to a hospital of twenty-five years ago in one of our own large cities. Let us imagine ourselves in the board room of this reputable institution. One of the ladies of the community some years before had made a gift of the brown Brussels carpet on which we now walk reverently. From the group of middle-aged men gathered around the substantial oak table in the center of the room, our eyes glance upward fascinated by the gas chandelier with its four jets protected by etched glass globes. Lace curtains hang at the windows, looped back stiffly with cords and tassels, their immaculate crispness attesting the loving care of the women's committee. A slight mustiness pervades the room, traceable to the carpet, the overstuffed furniture or more likely to the fact that the windows are kept tightly shut.

It is an occasion, a serious occasion. We have only to look at the perplexed faces of the men about the table and note the nods of approbation or dissent that punctuate the discussion.

"But she seems very young." The voice is thin and quavering. You follow it to the little white-haired gentleman seated to the right of the chairman.

"Not only very young, I would say," adds his neighbor with the paunch, "but damn good looking—almost too good looking for a hospital superintendent." He scratches the stubble on his chin perplexedly, wondering what his wife will say.

The conversation grows more earnest and confidential. Finally the chairman holds up his hand for silence.

"It is my feeling, gentlemen, despite your objections, which I may say are merely minor, that we should give this young woman a chance to see what she can do in running our hospital. She is young, to be sure,

**On to executive positions have gone many of the group at the left, seated so gravely amid sprays of mistletoe and holly. Above: tomorrow's executives.**

and pretty, that I'll not deny, but she comes well recommended, and strikes me as having a good head on her. What do you say we give her a try? We'll watch things closely, of course, and steer her when she seems to be getting off on a wrong course."

The suggestion made by the chairman is adopted, whereupon the new superintendent is invited to enter. Twelve pairs of eyes inspect her critically as she steps to the table. The chairman rises to greet her, smiling paternally.

"Miss Smith, my associates and I extend you an invitation to become the superintendent of this institution. We realize it is a great responsibility, and frankly there are those of us who fear for your youth and inexperience. But you'll accept our guidance and criticism, I'm sure."

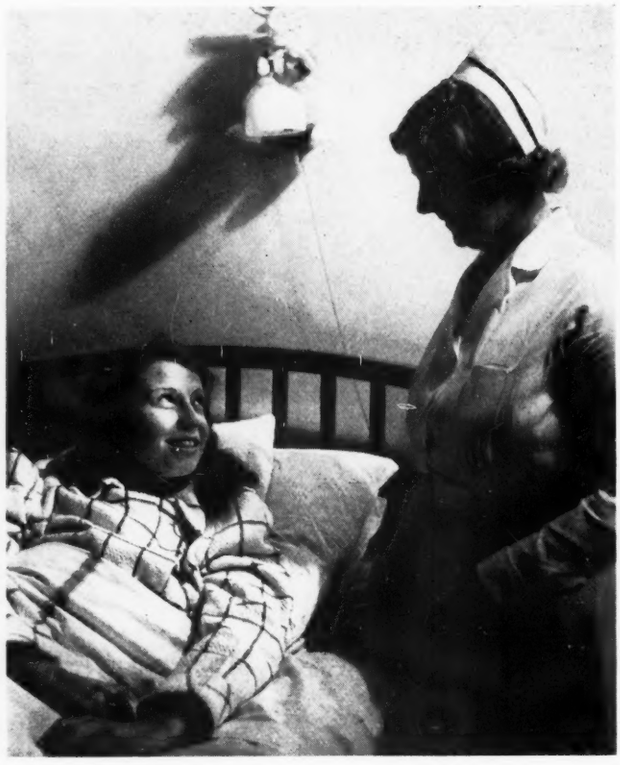
He hesitates and looks around the group for support. There is an embarrassing moment of silence. The young woman clutches her pocketbook tightly and turns to the speaker.

"You do me great honor, Mr. Chairman and gentlemen." Her voice is quiet but tense. "You will understand, however, that there are two sides to every question. After all, it is a superintendent you are engaging and, as such, I would expect complete and absolute jurisdiction over the entire operation of this institution. Unless I have your confidence to the point that I am the recognized head of the hospital at all times and under all conditions, I must refuse the post."

Only the ticking of the clock on the marble mantel breaks the silence. The speaker, flushed and breathless, starts to withdraw. "You gentlemen might like to reconsider your offer." The door closes after her.

Twenty-five years afterward, I am sitting in the private office of the same young woman. Her hair is just beginning to show signs of gray. Instead of the customary crisp white, her gown is gray, soft and clinging with a simple collar and cap of white handkerchief linen. The hospital is the same in name only. Instead of 125 beds, it now has an occupancy of 350 and its buildings cover almost a city block.

"And then what happened?" I lean forward waiting anxiously the answer that I know perfectly well.



**Some of the busiest hospital women find time to chat with each patient, a policy which wins friends for the institution and which assists in the patient's progress.**

Her eyes wander to the window through which a green terrace is plainly discernible where rows of little white beds are lined up in the sunshine. A smile plays about the firm lips. "Well, I got the job and I'm still here. But I don't know whether I'd have the nerve to speak up that way today or not."

"Neither bravery, nor courage, nor hope ever failed her."

How many times in recent years has the hospital woman summoned all the attributes with which Lord Knutsford accredited her and actually fought to keep her hospital doors open? If ever proof were needed of her stamina, it is written in the records of our depression era.

Another scene flashes before our mind's eye. The setting is a small town in the East; the time, five years ago. We had only started to feel the pinch of hard times but fear made heavy the hearts of everyone.

Like everything else, the little community hospital was suffering. It had exhausted what credit it had and the local tradespeople were becoming impatient. It looked as if there was but one course open, to admit defeat and close the doors. But the need for hospital service in the community was great and the frail little woman in charge was determined that the work must go on. She will excuse me, I know, when she reads this. Never were more indomitable will and courageous strength concealed in a delicate frame.

She summoned what resources there were and marched boldly to the town, appeared at a meeting of the Rotary Club and laid the facts plainly before its members.

"You can't permit the hospital to close its doors," she insisted. "Think what would happen to your wives and your families—to you, too, should sickness occur or you meet with some serious accident. With your cooperation, we'll pull through somehow. All I ask is your confidence that I may help the hospital to weather the storm and to continue to carry on its service."

She won the confidence, and the financial support as well, of the local merchants with the result that the crisis was met. Today, several years later, our lady of conviction and courage has the satisfaction of knowing that without her effort one community and its surrounding area would be without hospital facilities.

Few will ever know, however, the sacrifices that were entailed, the long hours of work almost to the point

**Librarians, housekeepers, social workers, technicians, dietitians, the list of hospital women continues on indefinitely.**

of exhaustion, the physical labor, the discouraging moments when, owing to discord within and without, all hope of bringing about strength and unity seemed lost. Yet the fight has been won—won, that is, as completely as any hospital problems are ever vanquished.

Today, when this hospital lady travels to meetings of her state association, there generally will be found sitting by her side two or three members of her board.

"She lived only for the hospital." Again we quote from Lord Knutsford. In that simple sentence is a fitting epitaph for countless hospital women whose entire lives are consecrated to serving others. Myriad duties from early morning until late at night, emergencies ever imminent, debar participation in social life. The hospital has well been likened to a world within itself.

It is a warm afternoon in summer. The little hospital attractively located on the edge of a lake in New England has had a particularly busy day.

The clock in the tiny reception room points to five, yet there is no cessation of activity. Lights burn in the operating room down the hall.

"The superintendent is busy. Will you wait? It won't be long. She is assisting in the operating room; the anesthetist is on vacation. Here she comes now."

"Excuse me, won't you? I haven't even had time to take off my gown. See you in one minute." She exits in an aura of ether.

"Now, let's have a talk." She is back again and seated at the old-fashioned roll-top desk that is piled high with papers. "Hectic times these, what with vacations, summer patients and a little bit of most everything."

A man's head appears around the corner of the door. "Can I do anything for you?"..."You want to pay your bill?" . . . "I should say you may. We never refuse money."

She disappears into the little office adjoining, hands the visitor a slip and returns to the old roll-top desk where from a battered cash register she extracts a bill and some coins with which to make change. "Thank you," she replies cheerily. "I hope John gets along nicely."

Her face looks drawn in the late afternoon light. "You see, we have to do a bit of everything in these parts." She sinks back on the worn black leather chair and sighs contentedly. "But I like it when there's action. That's why I'm happy most of the time."

It would be difficult to imagine hospitals without women—women in white carrying on efficiently in various departments and making their presence felt by wholehearted consecration to their professional duties. Women in the administrator's chair, in the office marked "Director of Nurses," dietitians, housekeepers, social service workers, technicians, record librarians—an endless list.

It has been said that the hospital is their entire world. That is not wholly true, for the years have witnessed them, in greater numbers, stepping outside to assume leading rôles in professional organizations.

Yet in this woman's world, who will say that the simplest service is not the greatest? There is a picture that to one staunch friend of hospital women seems to typify the great contribution they have made, without which hospitalization would never have progressed as it has.

Let us close our eyes and picture before us a brick building on the top of the hill. Its winding driveway is lined with fine old trees. We stop before the hospital and climb a short flight of stairs to the front entrance. The Colonial square hall serves also as reception room with the desk at one side. Swinging doors at the rear lead into the hospital.

The few chairs are taken. It is visiting time. Rough shod men shamble up to the desk to make inquiry. In the corner a child of 2 or 3 years is crying lustily, temporarily bereft of parents who are visiting upstairs. The wails grow louder and louder until—

The swinging doors open and a figure in spotless white appears. In one hand she holds several picture books; in the other, a child's chair. She smiles as she stands in the doorway and beckons the little girl to come to her. The child sobs convulsively but ceases crying. A dirty hand moistened by tear drops smudges the rosy cheeks. Hesitatingly, she walks over and permits two capable arms sheathed in white to encircle her. A story book is opened over which two heads touch in complete absorption — one dark and sleek, the other flaxen and curly. There are contentment, happiness.

R e m a r k a b l e — these hospital women!

# In Praise of the

ABRAHAM FLEXNER, M.D.

MAY I at this time draw the attention of the hospital world to the larger significance of the type of effort and the devotion that are embodied in the voluntary (philanthropic) hospital? This type of institution is a conspicuous example of what can be done by voluntary effort in a democratic country. It belongs in this respect with a host of other institutions privately endowed, supported and managed, which have long played and still play a leading rôle in American philanthropy and American education—Harvard, Yale, Columbia, Princeton and Chicago universities, the Boston Museum of Fine Arts, the Metropolitan Museum of Art, the American Museum of Natural History and the Philharmonic Symphony Orchestra.

I do not forget for a moment that the several states and the great cities have made and are making splendid contributions to philanthropy and education, but I call your attention to the peculiar and significant fact better illustrated in Great Britain and the United States than elsewhere, namely, the important rôle of voluntary effort in setting up high standards in education, in the practice of medicine, in the development of art by institutions, which might never have existed but for private initiative and voluntary effort.

We happen to be living in an era when, in consequence of human fallibility, the world has been overtaken by panic and distress such as private initiative alone cannot cope with. To an extent that could previously never have been expected, various government agencies have been compelled to provide relief where voluntary agencies have been unequal to the task.

**Accustomed to giving orders, yesterday's trustee sometimes gave them outside his sphere.**

I have no criticism to make on this score. It is a splendid thing that at a time of great social crisis the American nation has found itself possessed of a form of government that could relieve the poor, clothe the naked and provide support for the unemployed. Yet at this very moment when the government is doing all that it can humanly do in these various directions it behooves us to cling to the essence of our tradition of private effort and benevolent philanthropy.

The energy and devotion that have for three hundred years been applied to private philanthropy are, under our American system of government, largely unavailable for public life. The men and women who quietly and unostentatiously have built up the institutions which I have named have no relish for the rough and tumble of public life under democratic conditions. Shall this courage and devotion still find an adequate means of expression or shall they be allowed largely to run to waste as they run to waste in so many countries in the Old World?

Let me give you a concrete example of the way in which in this country private initiative has not only performed enormous social service but has enabled government itself to incorporate social services thus achieved into the very substance of our body politic. Certainly it will be not inappropriate to this occasion if I take as an example the field of medicine, though precisely the same result could be obtained by taking as an example any one of a dozen or more other fields.

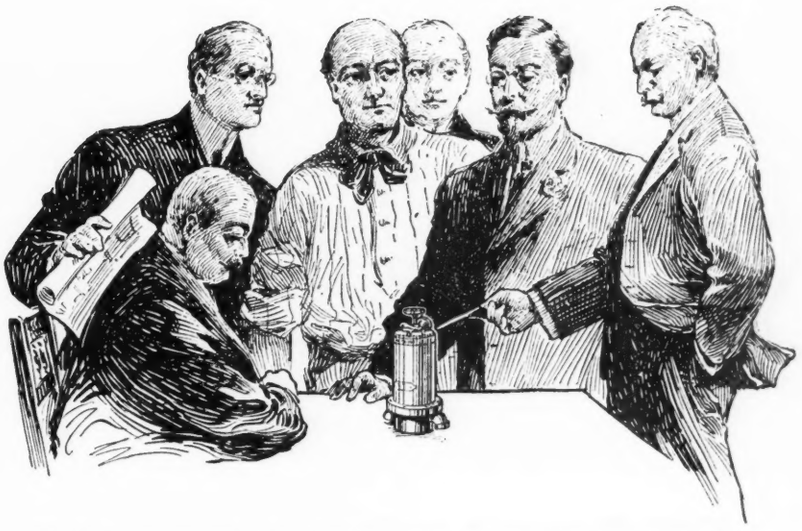
There was in America in 1890 no American medical school that could by any possibility be linked with the leading medical faculties of the Germany of that date and subsequently. There were besides in this country and in Canada 155 medical schools, almost all of them totally without the facilities or the ideals which at the same period prevailed in Germany.

Sporadic efforts had been made during the previous half century in various places and by various organizations to effect radical improvements in medical education. Viewed in the light of what has been accomplished since 1890, these sporadic efforts accomplished very little, indeed, but about 1890 an epoch-making event took place. With funds provided by a simple, far seeing Baltimore merchant the Johns Hopkins Medical School and the Johns Hopkins Hospital were established as integral parts of a university, itself the first of its kind in this country.

Private initiative did something in Baltimore at that time that neither the central federal government nor a state government nor a municipal government could possibly have accomplished then or perhaps even now. Private initiative, furnished with funds by a great benefactor, set up out of hand a hospital and a medical school, to the faculty and staff of which the best trained men obtainable in the whole world were called: Doctor Welch, who had been trained in Breslau and Strassburg; Doctor Osler, who had been trained in the great English hospitals, in Paris and in Germany; Doctor Halsted, who had been trained in Switzerland and in Germany; Doctor Kelly, who had been trained in Germany; Doctor Mall, Doctor Abel, Doctor Howell and others who brought to this country ideals up to that time unknown. Modestly and inconspicuously, they gathered about themselves a small group of disciples eager to develop scientific medicine.

Many of the students of that era are now themselves occupied in the conduct of great scientific enter-

# Trustee



**Having summoned the janitor into its august presence, this board of trustees (1913 variety) proceeds to discuss the finer points of a small mechanical purchase; it wouldn't happen in 1938.**

prises in medicine. The Rockefeller Institute for Medical Research would never have been founded but for the fact that the Johns Hopkins Medical School and Hospital preceded. The director of the scientific laboratories of the Montefiore Hospital in New York was one of the students who worked under the great masters in Baltimore, whose names I have mentioned.

The example set in Baltimore spread like an epidemic. The men who were trained in Baltimore were medical missionaries who carried into our great universities new ideals of medical teaching, medical research and hospital organization.

Within fifteen years or less a distinct cleft appeared and there were on the one side institutions struggling to reproduce the spirit and the effort characteristic of the Johns Hopkins Medical School, while on the other side were institutions upon which this spirit had thus far made no impression. By this time public opinion began to be interested. The eyes of state legislators were opened. The medical profession itself became enlightened.

Instead of the low standards under which it had previously been possible to conduct medical education and medical practice, a concerted effort was suddenly made that almost in the twinkling of an eye transformed both; the schools that had learned something have survived, improved and expanded; the schools that had learned little or nothing began to shrivel and die away. The states that had formerly licensed illiterates who listened to didactic courses now began to limit the practice of medicine to those who had been properly prepared and properly trained. Within a decade our 155 medical schools shrank to little more than 50 and the total resources applied to the conduct of medical schools and hospitals increased from a relatively small sum to hundreds of millions.

All this was, in the first place, the result of private effort, private initiative and private gifts. Few of the names of those concerned in this revolutionary movement are now known beyond the small circle of those who have made it their business to know.

It was private effort and private money and private devotion and private initiative that in this matter set the pace; and it is this same private effort and private initiative and private devotion and private means that have created, maintained and elevated the voluntary hospital.

It is undoubtedly the government which must in course of time incorporate in its statutes the standards of efficiency that have been first worked out generally by private institutions and then by public institutions as well. Government has thus a very distinct service to perform, for, as social standards are elevated and refined, law can be made that public opinion will sustain and enforce.

Thus private effort and public effort are in no wise incompatible. There is no inconsistency between the existence of institutions under private initiative, support and control and the existence of publicly maintained institutions of the same character and of equal quality. Only let me warn you that, unless private means continue to exist, the rôle hitherto played in our history by private enterprise in education, in art and in philanthropy is doomed to shrink in importance and perhaps ultimately to disappear.

Let me remove from your minds a possible misapprehension. I am making no indirect plea for sweat shops or stock-watering or any business or commercial practice by means of which vast fortunes can be unsocially gathered. I wish only to point out to you the fact that in the long run what the law can accomplish depends not upon what is written upon the statute book—else we actually should have had prohibition during the last ten or fifteen years—but upon the state of public opinion and the sincerity of the standards of dealing which men employ in their relations with one another.

A democratic government is self-governmental in an extreme sense. Men engaged in business must make it absolutely impossible for others similarly engaged to indulge in practices that lower the tone of social life. When ideals have thus been established by men who have character, intelligence, ability and public spirit, they can to some extent be incorporated in the law. Our main reliance, however, must forever be upon the quality of the individual, and our laws must leave to him the means by which he can carry forward, as only groups of congenial and devoted men can locally carry forward, the pace setting enterprises upon which the level of civilization actually depends.

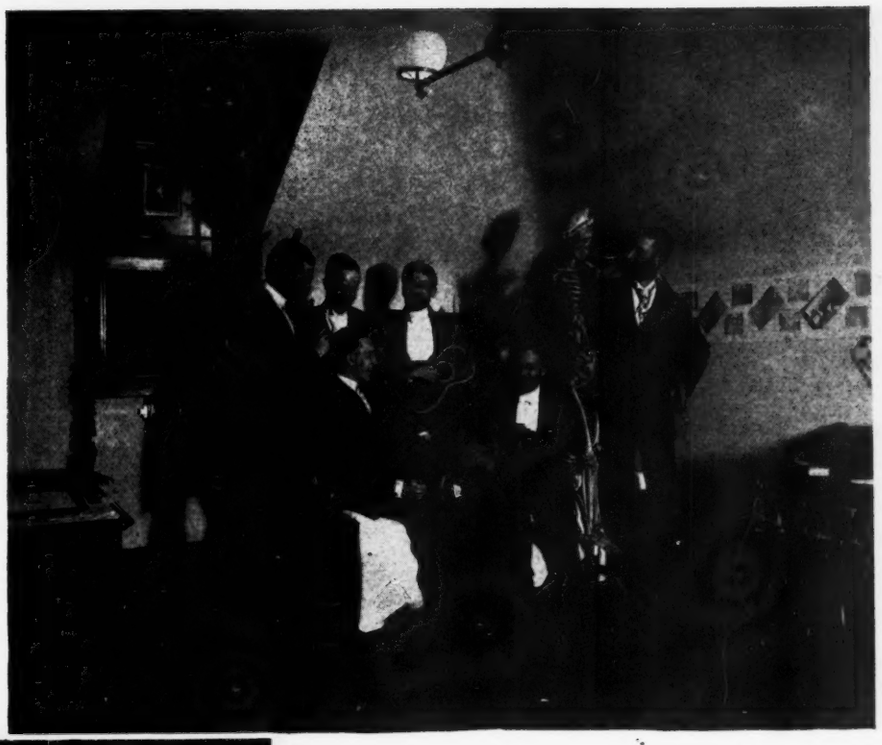
# FADED LEAVES FROM A

Was night duty ever as sweet as this? Things must have gone on under the hospital gas jets that are not tolerated in an electrical age.

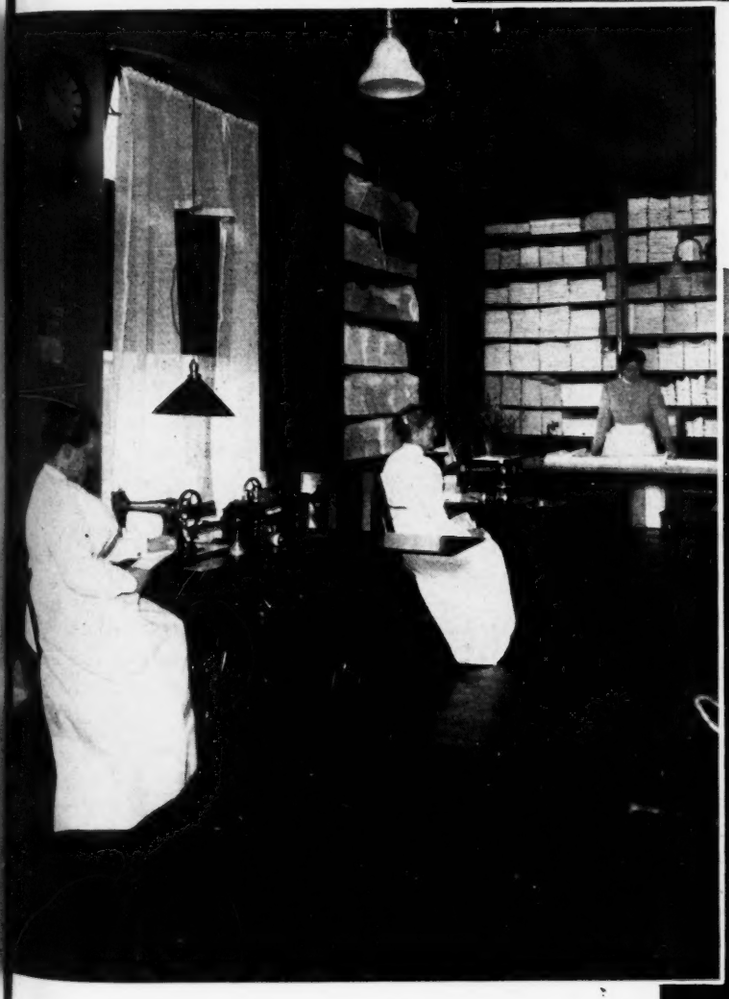
Precious the hours off duty when in a bedroom with all modern conveniences nurses could brush up on Donahoe's Manual and Nutting & Dock.

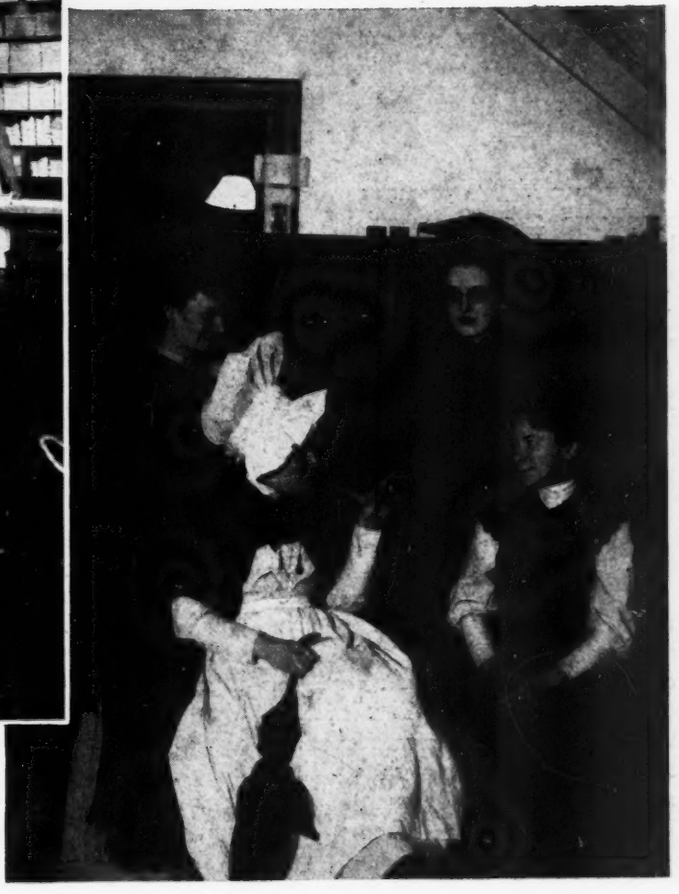
In carpenter shop (left) and linen room (right) hand and foot power ran the machines, and a quiet serenity pervaded the place; sometimes it does today, although not often.

# FAMILY ALBUM



In their quarters in the hospital attic six doctors serenade a lady, smuggled up the stairs, no doubt, against all rules regarding lady callers.





High jinks in the nurses' home. They had better be careful for some of their superiors will not appreciate these apt impersonations of themselves.

# The Making of a Magazine

MILDRED WHITCOMB

### Before 1913

A PUBLICATION'S prenatal period is likely to be long. In this respect The MODERN HOSPITAL was typical. It is necessary to turn back beyond the actual birth date to account for the somewhat precocious infant that, in September 1913, let out a lusty cry heard halfway round the world.

The magazine's founder for a decade had been publishing a unique sort of periodical called the *Interstate Medical Journal,* noteworthy because of its collective abstracts covering the subjects of the day. Associated with him as contributing editors were more than a dozen of the future bigwigs of medicine—Willard Bartlett, Nathaniel Allison and Hugo Ehrenfest, to name three.

These up and coming young men were recently returned from the European centers of scientific culture: Berlin, Heidelberg, Vienna, Paris. Apparently it amazed no one that they could read several languages — America was far from medically self-sufficient in those days —and read them they did with regularity and precision. They had to because the publisher of the *Interstate Medical Journal* ordered delivered monthly to their desks for abstracting and review the current medical literature of all Europe and America.

### "Conversation at Midnight"

The nucleus of this brilliant Aesculapian constellation was in St. Louis. There once a month they met to plan successive issues of the journal that was bringing to American physicians the first really comprehensive accounts of Ehrlich's "606" and other epochal discoveries.

Talk always took them well into the night. Over their cigars and steins they surrounded the problems of medicine, life and the universe at a single sitting. If their "conversation at midnight" sometimes resounded with a sharp clash of verbal swords, there was one surefire subject of brotherly accord: the need for more coordinated effort on the part of the profession.

Logically the current of thought sometimes shifted to the hospital and the larger part it must shoulder in the medicine of the future. The Mayo Clinic at that time was making a dramatic demonstration of organized teamwork in diagnosis and treatment.

"Why can't we have closer tie-ups between doctors and hospitals?" someone would ask. "If there was ever an example of haphazard growth it is in our hospitals."

"Politics has such a stranglehold on our public hospitals that their esophagi are slowly closing. We can stir up a little professional excitement over hospitals in our own magazine. Let's get going."

### Two Inciting Occurrences

They were beginning to "get going" in the medical journal when two incidents occurred, totally unrelated. From the perspective of a quarter century these incidents appear to be the inciting forces of the prospective hospital publication.

The St. Louis Free Skin and Cancer Hospital overflowed with patients and more clamored for admission to its meager facilities. The work being done there found a substantial friend in George D. Barnard, who decided to give money to provide a modern plant, the one now known as the Barnard Free Skin and Cancer Hospital.

Mr. Barnard and Dr. Martin F. Engman, chief of staff of the present Barnard, sought the advice of the publisher of the *Interstate Medical Journal,* Dr. Otho F. Ball. They wanted his help in unearthing information here and abroad on planning and equipping this special type of hospital.

An extended and earnest study of special and general hospitals was begun. Promptly it uncovered the deplorable dearth of organized material on hospital construction, organization, equipment and administration.

While this search was pressed Incident No. 2 occurred. The mayor of St. Louis—God rest his soul—made a speech one night.

"The St. Louis City Hospital," he stated impressively over his protruding waistcoat, "has the lowest per capita cost and the lowest food cost of any similar institution in the length and breadth of this great republic."

His Honor might have added in his list of the hospital's "lows" the low quality of service the institution was providing. (Under the courageous Frank E. Chapman, backed by a nonpolitical board and supported by the medical profession, it later emerged into an institution of quality.)

Obviously the mayor's speech was a direct challenge to anyone thinking long thoughts on the improvement of hospitals.

It was at this period that business and industry made a sensational discovery. They called it "efficiency" and under its banner they brought about a (practically) bloodless revolution.

A few hospitals rallied to the efficiency battle cry, but the rank and file, ignorant of the rich ground being gained, stuffed their ears with sterile cotton and were not disturbed by the gunfire. Many did not even know what all the shooting was about.

The picture, then, in 1913—for the magazine's birth is now near—was that of 6665 institutions claiming recognition as hospitals and having a reported capacity of more than 600,000 beds. An investment in lands, buildings and equipment was estimated at a billion and a half dollars.

Potential leadership was there but no live pulsating publication stim-